_____ _____

Client Name Chart #

8810 S Yale Ave Suite K
Tulsa, OK 74137
918-760-5243; FAX:844-482-2279
info@chriskingcounseling.com

## Child/Minor Assessment

**ASSESSMENT/ SCREENING PORTION:**

Agency Name: Chris King Counseling Services, LLC Provider ID: 200559250 B Date: _____

Name: LAST: _____ FIRST: _____ MIDDLE INT.: _____

MAIDEN: (If Applicable) _____

Source/Provider of Information: _____Phone #: _____

Address/City/St./Zip/Co;

_____

Phone #: _____DOB: _____ Age: _____Gender: ____ Male ___ Female

Best way to contact you? _____Confidentiality Issues? _____

E-mail Address: _____

Can CKCS contact you with appt. reminders and updates? (yes no)

If yes- email or txt: _____

How did you hear about CKCS? _____

What would you like help with (reason for seeking services)?

_____
_____

What are your immediate/urgent needs(including medical)?:

_____
_____

Currently receiving or past services? _____yes _____no If yes, where? _____

Residing with: (alone, family, friends…) _____ _____ # in household: _____

Source of Income: ___Employment___ Full-Time___ Part-Time ___ Homemaker ___SSI ___SSDI ___Food Stamp ___TANF ____Other (if other, please explain) : _____

Insurance: __Private __Medicaid __Medicare __Private Pay __Other: __ (if other, please describe): _____

Insurance ID#_____ SSN: _____

**Referred by (Primary): _____(Secondary): _____**

Reason for referral: _____

Name of School attending: _____

_____ _____

Client Name Chart #

**Race (check all that apply): _____Native American/Alaskan Indian _____Black/African American _____Asian___ Hawaiian/Pacific Islander ___White ___Other___ Ethnicity: Hispanic/Latino____**

**Emergency Contact Name: _____Relationship: _____**

**Emergency Contact Phone#:_____**

**Emergency Contact Address: _____**

**Guardian/Custodian: _____ Relationship: _____**

**Preferred Language: _____**

**Need any special help/equipment? ____ yes ____no If yes, describe_____**

**Assessment questions- Answer yes, no, n/a (not applicable).**

**Behavioral/Substance Abuse**

Within the last 90 days (3 months) have you had a significant period in which you have experienced:

- Been preoccupied with drinking alcohol and/or using other drugs? **yes, no, n/a.**
- Tried to stop drinking alcohol and/or using other drugs, but couldn't? **yes, no, n/a.**
- Had problems caused by drinking/using drugs, and you kept using? **yes, no, n/a.**
- Are you misusing and prescription medication or over the counter products? **yes, no, n/a.**
- Problems with Gambling? **yes, no, n/a.**
- Had problems with behavior that gets you into trouble at home/ school/ work? **yes, no, n/a.**
- Experienced significant arguing and escalation with other people? **yes, no, n/a.**
- Problems controlling your anger, or had volatile or violent behavior? **yes, no, n/a.**
- Been charged with crime, been arrested, or been incarcerated? **yes, no, n/a.**

**PLEASE COMMENT ON ALL YES ANSWERS ABOVE:**

_____

_____

**Emotional/Trauma**

During the past year (12 months) have you:

- Serious Depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your activities)? **yes, no, n/a.**
- Are you feeling mad, sad, hopeless, nervous, or have you had a change in your sleeping, eating, or school performance? **yes, no, n/a.**
- Serious Anxiety of tension (felt uptight, worried, unable to relax)? **yes, no, n/a.**
- Being prescribed medication for psychological/emotional problem? **yes, no, n/a.**
- Thoughts of harming yourself? **yes, no, n/a**
- Thoughts of harming others? **Yes, no, n/a**
- An attempted suicide? **yes, no, n/a.**
- Hallucinations (heard/seen things others don't hear/see)? **yes, no, n/a.**
- Experienced a traumatic event, natural disaster, war, accident, injury, loss of a loved one? **yes, no, n/a.**
- Experienced bullying or harassment that had a significant impact on your life? **yes, no, n/a.**
- Had periods of time where you felt that you could not trust family or friends? **yes, no, n/a.**
- Ever been afraid of your partner and/or family member? **yes, no, n/a.**
- Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened? **yes, no, n/a.**

**PLEASE COMMENT ON ALL YES ANSWERS ABOVE:**

_____

_____

_____ _____

Client Name Chart #

**Social/Recreational**

During the past year (12 months) have you:

- Had problems getting along with people that cause significant negative impact on your life? **yes, no, n/a.**
- Felt isolated or unable to relate to people? **yes, no, n/a.**
- Are you spending less time with friends, care less about your appearance, or feel alone? **yes, no, n/a.**
- What social groups do you participate in and how often? _____
- What recreational/ leisure activities do participate in and how often_____

**PLEASE COMMENT ON ALL YES ANSWERS ABOVE:**

_____
_____

**Vocational**

During the past year (12 months) have you:

- Been unemployed for a significant period of time? **yes, no, n/a.**
- Been unsatisfied with job in a way that has a negative impact on your life or your family? **yes, no, n/a.**
- Experienced significant stress on the job? **yes, no, n/a.**
- Been desiring a job or career change? **yes, no, n/a.**

**PLEASE COMMENT ON ALL YES ANSWERS ABOVE:**

_____
_____

**Educational**

Highest level of education completed: _____For students: Approximate days absent this semester: _____

During the past year (12 months) have you:

- Had problems with school performance that had a negative impact on your life? **yes, no, n/a.**
- Had other problems in the school setting that had a negative impact on your life? **yes, no, n/a.**
- Participated in an individual education plan (IEP)? **yes, no, n/a.**
- Been suspended or expelled? **yes, no, n/a.**

**PLEASE COMMENT ON ALL YES ANSWERS ABOVE:**

_____
_____

**Family**

During the past year (12 months) have you:

- Had trouble in family relationships that have a negative impact on your life? **yes, no, n/a.**

  Is there family history of mental illness, or suicide? **yes, no, n/a.**

  Is there family history of addiction? **yes, no, n/a.**

  Is there adoption or foster care in your immediate family? **yes, no, n/a.**

**PLEASE COMMENT ON ALL YES ANSWERS ABOVE:**

_____
_____

_____ _____

Client Name Chart #

**Mental**

- Have you received counseling or in-patient treatment before? **yes, no, n/a.**

  If yes, describe including any diagnosis you received_____

**CLIENT MEDICATION INFORMATION**

To be used document all medication used for treatment of mental health issues and also any physical health issues by client:

| **Medication prescribed** | **Dosage** | **Frequency** |
|---|---|---|
| | | |
| | | |

_____ _____

Client Name Chart #

## ASSESSMENT HEALTH SCREENING

**Client Name: _____ (*Please circle one)***

| | |
|---|---|
| **Do you have chronic or significant physical pain?** | **Yes No** |
| **Do you have unexplained bleeding?** | **Yes No** |
| **Do you have any unexplained coughing?** | **Yes No** |
| **Do you have any periods of dizziness?** | **Yes No** |
| **Do you experience any shortness of breath?** | **Yes No** |
| **Do you have any persistent fever of unknown cause?** | **Yes No** |
| **Have you been treated for head lice?** | **Yes No** |
| **Are you positive for Hepatitis C?** | **Yes No** |
| **Are you positive for HIV/AIDS?** | **Yes No** |
| **Problems sleeping or excessive sleeping?** | **Yes No** |
| **Appetite/ food issues/ eating disorder history?** | **Yes No** |

**If yes, explain:**

_____

_____

**Have you discussed physical complaints with doctor? Yes _____No_____ When? _____**

**Doctor Name: _____ Phone #: _____**

**Do you need a referral to a doctor? Yes _____No _____**

**Approximate date of last health examination: _____Immunizations up to date? Yes _____ No_____**

**Comments on above questions:**

_____

_____

**Are there any other health risks/factors or family history that we should be aware of? Yes___ No___**

**Please explain:**

_____

_____

_____ _____

Client Name Chart #

**Interview narrative to be included on electronic chart note in client record completed by participating clinician.**

_____

_____

**Client/ Parent Signatures indicating face to face screening/ assessment**

**Chris King Counseling Services, LLC. CLIENT ASSESSMENT SIGNATURE VERIFICATIONS**

Client Name: _____

Provider: _____

Assessment Date and Time Completed: _____

**CLIENT ACTIVE PARTICIPATION STATEMENT: I/we (client/guardian) have participated in a mental health assessment/ interview with CKCS. The assessment reviews items including client history, presenting problems, behavioral, substance use, emotional/ trauma, physical, social/ recreational, vocational, family interaction.**

I have the following comments/response:

_____

_____

_____ _____ _____ _____

(Consumer Signature, 14 or older) (Date) (Parent/Guardian Signature) (Date)

If unable to legibly sign document, reason: _____

**LBHP Signature** indicates completion of the face to face assessment to determine medical necessity and appropriate level of care including the evaluation of all pertinent information by the other service practitioners and the member, and a review of the current service plan:

_____ _____

(Responsible LBHP Signature, Degree/License/Under Supervision (Date)

_____ _____

Client Name Chart #

Chris King Counseling Services, LLC
8810 S Yale Ave Suite K
Tulsa, OK 74137
918-212-8064; Fax: 844-482-2279
chriskingcounseling@gmail.com

**SCHOOL CONSENT FORM**

I, _____**(parent/guardian)** give my permission for
**(please print)**
**(Staff Member):** _____ with Chris King Counseling to provide
**(please print)**
counseling for my child **(Client Name)** _____ at his/her school
**(please print)**

_____.
**(Name of school)**

I also give permission for information to be shared between CKCS staff and school personnel including teachers and administration regarding performance, behavior, and needs to benefit the student.

_____ _____

(Signature of Legal Guardian) (Date)

_____ _____

(Signature of Staff) (Date)

_____ _____

Client Name Chart #

**Chris King Counseling Services, LLC.**

**CONSENT FOR TREATMENT AND PARTICIPANT ORIENTATION SUMMARY:**

**Clients will read and initial each section if it applies/if it does not apply mark N/A:**

_____ I voluntarily agree to treatment and services from Chris King Counseling Services, LLC. I understand the reasons for this treatment and the services recommended.

MEDICATION MANAGEMENT

_____ I have prescribed medications and will provide consent for consultation with my physician. I further understand that Chris King Counseling Services, LLC does not provide medication monitoring as a service and that I should consult my physician with all needs or concerns related to medication.

DURATION

_____ This consent for treatment ends after my discharge from services, except that information necessary for payment for services provided may be provided after discharge from services.

CONFIDENTIALITY

_____ I understand my information is confidential. Information is not released to other agencies or persons without my written consent except under a legitimate subpoena; in a medical emergency; to meet the legal requirements of reports of abuse to children or elders; or if I present a danger to myself or others. I have been offered information on legal requirements and limitation of mental health confidentiality.

CLIENT RIGHTS

_____ I have received a copy of the synopsis of my client rights and have discussed with the agency. I am satisfied with how my rights were explained, and I understand them. I acknowledge that I can receive a full bill of client rights upon my request.

**PAYMENT SOURCE RELEASE OF INFORMATION**

_____ I understand those agencies or insurance or others paying for my treatment services may review my records or may require my provider to provide information from my client file. I agree and hereby authorize Chris King Counseling Services, LLC. to release any and all information requested by the agencies or parties paying for my services. I understand this specific consent for release of information ends only after third party payer claims are satisfied.

**CERTIFICATION/ACCREDITING REVIEW**

_____ I understand that my records may be reviewed by State agencies certifying receipt of services and/or compliance with requirements, or by accrediting agencies verifying the quality and completeness of services I receive. I understand and agree to the above conditions.

**CONSENT FOR FOLLOW UP**

I_____ agree _____ do not agree that I can be contacted for follow up and outcome of services.

**PARTICIPANT RIGHTS AND RESPONSIBILITIES**

_____ I have been offered a copy of the Client Orientation with my rights, responsibilities, and grievance/input procedures and the HIPPA privacy laws. I understand the information presented to me.

**COURT REPORTS AND SUBPOENAS**

_____ I understand that Chris King Counseling Services, LLC. does not provide forensic or child custody evaluations. I understand that fees may be associated with reports for court and responses to subpoenas.

**SAFETY AND EMERGENCY PREPAREDNESS**

_____ I understand the safe places for emergency shelter, where to go, and what alarms of signals are.

**PHYSICAL CARE**

_____ I understand my counselor and my physician need to consult at times.

Client(if over 14): _____Date: _____

Guardian: _____Date: _____

Staff: _____Date: _____

_____ _____

Client Name Chart #

Chris King Counseling Services, LLC
8810 S Yale Ave Suite K
Tulsa, OK 74137
918-212-8064; Fax: 844-482-2279
chriskingcounseling@gmail.com

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**
**(SCHOOL)**

I _____, _____ hereby authorize

**(Name of Client)** **( Client Date of Birth)**

Chris King Counseling _____ and its duly appointed agents and

**(Name of Staff)**

Employees to: ____X____ release to: ____X____ Obtain from: _____

**(Name of Individual Title, School and Address)**

the following information: **Behavior in an educational setting, grades** .

Purpose: **Coordination of Services** .

This release is only valid from _____ to _____.

**(beginning date)** **(end date)**

Treatment services are not contingent upon, or influenced by, the client's decision to or not to permit the release of this information. The client's consent shall be freely and voluntarily given. **The information authorized for release may include records which may indicate presence of a communicable or venereal disease which may include, but not limited to diseases such as hepatitis, syphilis, gonorrhea, and AIDS.** Psychiatric records: Federal law provides that the psychological or psychiatric records may be provided to a patient only if the treating physician/practitioner consents to release or upon request of a court order, issued by a court of competent jurisdiction. Therefore, the agency will not release psychological or psychiatric records to patients, their guardians, or agents (including attorneys) except with the consent of the treating physician or upon receipt of a court order, issued by a court of competent jurisdiction. Drug and alcohol records: Confidentiality of drug and alcohol records is protected by Federal Law, Federal Regulations (42 CFR part 2) prohibit you from making further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42CFR part 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. The Federal Rules restrict use of the information to criminally investigate or prosecute any alcohol/drug patient. I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.). I do not authorize further release to any other party. I do understand that the agency and its staff, employees, officers, and directors cannot be responsible for the confidentiality disclosed after said information has been released pursuant to this authorization, and hereby release them from any liability arising from such disclosure. I authorize this consent to release confidential Information.

Client(if over 14): _____ Date: _____

Guardian: _____ Date: _____

Staff: _____Date: _____

_____ _____

Client Name Chart #

Chris King Counseling Services, LLC

**Chris King Counseling Services Client Bill of Rights**

- Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process law.
- Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.
- No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.
- Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged as defined by law. Additionally, each consumer shall have the right to the following:
- Allow other individuals of the consumer's choice participate in the consumer's treatment and with the consumer's consent;
- To be free from unnecessary, inappropriate, or excessive treatment;
- To participate in consumer's own treatment planning;
- To receive treatment for co-occurring disorders present;
- To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and
- To not be discharged for displaying symptoms of the consumer's disorder.
- Every consumer's record shall be treated in a confidential manner.
- No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.
- A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.
- Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
- No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

I, the undersigned, have read, or have had read to me, the above rights. I acknowledge that my rights have been explained to me.

Client (if over 14): _____ Date: _____

Guardian: _____ Date: _____

Staff: _____ Date: _____

Translator (if applicable): _____ Date: _____

_____ _____

Client Name Chart #

**Chris King Counseling Services, LLC.**

**TREATMENT ADVOCATE DESIGNATION FORM**

Clients have the choice to name or not name treatment advocate who is a family member or concerned individual. This advocate may have the level of involvement that the client chooses and will always act in the best interest of the client and comply with all the conditions of confidentiality.

There will be no limitations imposed on a client's right to communicate whether by phone, mail, visitation with the advocate except to the extent that reasonable times and places are established.

Advocates may participate in the treatment and discharge planning of the client being served to the extent consented to by the client and permitted by law. Clients and advocates will be notified of treatment and discharge planning appointments at least 24 hours in advance.

Choice regarding treatment advocate:

I _____ choose to name a treatment advocate:

**(Client Name)**

**(CIRCLE) YES Or NO.**

**If yes**, name and contact info of treatment advocate:

_____

**If yes**, indicate level of involvement of advocate:

_____ Limited Involvement, but ability to attend treatment and discharge planning sessions and provide input.

_____ Full involvement including ability to speak and choose in client's best interest concerning treatment, if client is incapacitated.

**The client may revoke or change the designation of the treatment advocate for any time or reason. This form can be reviewed and updated at each point of treatment planning for updating and amendment.**

Client(if over 14): _____Date: _____

Guardian: _____Date: _____

Staff: _____Date: _____

Translator (if applicable): _____Date: _____

_____ _____

Client Name Chart #

## GRIEVANCE PROCESS

**PROCEDURES FOR CLIENT GRIEVANCES AND OTHER ISSUES**
**CKCS, LLC wishes to maintain an open line of communication, giving the client adequate opportunity to express opinions, recommendations, and complaints. Please talk to us and let us know if you have any complaints about your experience with us.**
**WHO MAY FILE A GRIEVANCE:**
**Any client under the care of any agency or anyone interested in the welfare of a client receiving care at any agency (e.g. relative, foster parent, DHS Caseworker, DOC/Probation Officer) may at his/her discretion provide in writing any opinion or recommendation.**
**WHAT COMPLAINTS ARE CONSIDERED:**
**The complaint may be about any rule, policy, action, decision, or condition made or permitted by any agents or any other person paid by the agency to care for a client of any agent.**
**WHEN A GRIEVANCE MAY BE FILED:**
**It is important that grievances be filed as soon as possible. Grievances should be filed within FIVE days of the action grieved.**
**HOW TO FILE A GRIEVANCE:**
**You have the right to file grievances, to receive a written response to your complaint and to appeal if you are not satisfied with the response. If any person attempts to deny you these rights or penalize you for filing a grievance, contact the Grievance Coordinator Ryan Myers at (918) 481-1111.**
**TO INQUIRE ABOUT A GRIEVANCE OUTCOME:**
**You can contact the Grievance Coordinator Chris King LPC (available at 918-557-6128)**
**or Local Grievance Advocate Carmela Christensen at (available at 918-212-8064) you may also Contact ODMHSAS Client Advocate Dept. at 1-405-248-9037 or 1-866-699-6605**
**Clients can also contact ODMHSAS at:**
**ODMHSAS Client Advocate Dept.**
**405-248-9037 (OKC metro)**
**866-699-6605 (Statewide)**
**TO FURTHER A GRIEVANCE, you may wish to contact DHS/Client Advocacy Office at:**
**ADVOCACY OFFICE**
**900 E MAIN**
**BOX 151**
**NORMAN, OK 73070**
**PHONE: 1-405-522-2720**
**For concerns or complaints about the Notice of Privacy Practices or Privacy Rule contact:**
**OFFICE OF CIVIL RIGHTS**
**US DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**200 INDEPENDENCE AVENUE, S.W.**
**ROOM 509F, HHH BUILDING**
**Washington, DC 20201**

**OCR HOTLINES/VOICE 1-800-368-1019**

**FAX 1-202-619-3818or online at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

**I received a copy and it was explained to me by _____ on_____**

**Staff Print Name** **Date**

_____ _____

**Signature of Client (14 yrs. or older)** **Date**

_____ _____

**Signature of parent/guardian** **Date**

_____ _____

**Signature of Staff** **Date**

Client Name _____ Chart # _____

# Trauma/Risk Assessment

Check all risk and protective factors that apply. To be completed following the patient interview, review of record (s) and/or consultation with family members and/or other professionals.

## General Consumer Information

In the past few weeks, have you been feeling bad about yourself/or that you are a failure /or have let yourself or your family down?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

In the past few weeks, have you had trouble falling asleep, staying asleep or sleeping to much?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

In the past few weeks, have you had thoughts about harming or killing yourself?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

Are you having thoughts or plans of killing yourself right now?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

In the past few weeks, have you felt the urge to hurt others?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

In the past few weeks, have you been having thoughts about hurting or killing others?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

Are you having thoughts of killing or harming others currently?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

## Additional Information

Please list any concerns or comments below.

_____

_____

## Personal Information

Please provide the following information.

First Name _____ Last Name _____ Gender _____ Age _____

Address _____ City _____ State _____ ZIP Code _____

Email _____ Phone _____

Provide the following resources to all Consumers
24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Espanol: 1-888-628-9454
24*/7 Crisis Text Line : Text "HOME" to 741-741

_____ _____

Client Name Chart #

Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Additional Information (if applicable):

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Client Name Chart #

**CLIENT COPY**

**Chris King Counseling Services, LLC.**

**TREATMENT ADVOCATE DESIGNATION FORM**

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Advocates may participate in the treatment and discharge planning of the client being served to the extent consented to by the client and permitted by law. Clients and advocates will be notified of treatment and discharge planning appointments at least 24 hours in advance.

Choice regarding treatment advocate:

I _____ choose to name a treatment advocate:

**(Client Name)**

**(CIRCLE)** **YES** **Or** **NO.**

**If yes**, name and contact info of treatment advocate:

_____

**If yes**, indicate level of involvement of advocate:

_____ Limited Involvement, but ability to attend treatment and discharge planning sessions and provide input.

_____ Full involvement including ability to speak and choose in client's best interest concerning treatment, if client is incapacitated.

**The client may revoke or change the designation of the treatment advocate for any time or reason. This form can be reviewed and updated at each point of treatment planning for updating and amendment.**

Client(if over 14): _____Date: _____

Guardian: _____Date: _____

Staff: _____Date: _____

Translator (if applicable): _____Date: _____

_____ _____

Client Name Chart #

**CLIENT COPY**

## GRIEVANCE PROCESS

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**The complaint may be about any rule, policy, action, decision, or condition made or permitted by any agents or any other person paid by the agency to care for a client of any agent.**
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**It is important that grievances be filed as soon as possible. Grievances should be filed within FIVE days of the action grieved.**
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**Clients can also contact ODMHSAS at:**
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**405-248-9037 (OKC metro)**
**866-699-6605 (Statewide)**
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**900 E MAIN**
**BOX 151**
**NORMAN, OK 73070**
**PHONE: 1-405-522-2720**
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**US DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**200 INDEPENDENCE AVENUE, S.W.**
**ROOM 509F, HHH BUILDING**
**Washington, DC 20201**

**OCR HOTLINES/VOICE 1-800-368-1019**

**FAX 1-202-619-3818or online at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

_____ _____

Client Name Chart #

**CLIENT COPY**

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- No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.
- Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged as defined by law. Additionally, each consumer shall have the right to the following:
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- To be free from unnecessary, inappropriate, or excessive treatment;
- To participate in consumer's own treatment planning;
- To receive treatment for co-occurring disorders present;
- To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and
- To not be discharged for displaying symptoms of the consumer's disorder.
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- No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.
- A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.
- Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
- No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

I, the undersigned, have read, or have had read to me, the above rights. I acknowledge that my rights have been explained to me.

_____ _____

Client Name Chart #