SERENITY HEALTH

INTAKE / REGISTRATION FORM

Name of Patient: _____ **Date of Birth**: _____

Name of Parent/Guardian: _____ **Do you have custody papers:** ☐ **Yes** ☐ **No**

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home phone: _____ **Cellular:** _____ **Other:** _____

Email: _____

Would you like to be reminded of your appointment and how? ☐ **YES** ☐ **NO, DO NOT REMIND ME!**

☐ **Text:** _____ ☐ **Phone call:** _____

☐ **Email:** _____

When is the best time to call you? _____

Do you have a Primary Care Doctor? _____ **If yes, doctor's name:** _____

Do you have a Psychiatrist? If yes, doctor's name: _____

Primary Insurance: _____ **#ID number** _____ **# Subscription:** _____

Person responsible of insurance: _____ **Date of Birth:** _____

Relation to the patient: _____ **SS# *(optional)*:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Secondary Insurance: _____ **ID#: Number** _____ **Subscription#:**_____

Person responsible of insurance: _____ **Date of Birth:** _____

Relation to the patient: _____ **SS# *(optional)*:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Source of Referral: _____

Signature: _____ **Date:** _____

Please Note: If you would like to leave Emergency Contact information on record. Please let the front desk know so you can be assisted in completing a release of information of protected health records.

SERENITY HEALTH

PATIENT INFORMATION SHEET

Patient Name: _____

Primary Reason for today's visit: _____

Allergies {Include drug, food and environmental): _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins:

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY: {Please circle all that apply)

- ☐ ADHD
- ☐ Alcoholism
- ☐ Allergies, seasonal
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia (irregular heart beat)
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Heart Attack
- ☐ Bleeding Problems
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Crohn's Disease
- ☐ COPD/Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes (1 or 2)
- ☐ Diverticulitis
- ☐ DVT (Blood Clot)
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Parkinson's Disease
- ☐ Histal Hernia
- ☐ Cancer
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Lupus
- ☐ Liver Disease
- ☐ Muscular Degeneration
- ☐ Neuropathy
- ☐ Osteopenia/Osteoporosis
- ☐ Peptic Ulcer
- ☐ High Blood Pressure
- ☐ Psiorasis
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Bladder Problems/Incontinence

Other medical problems not listed above:

_____

_____

Surgical History: Please list all prior surgeries and approximate dates performed

Date (Month/Year) Reason

_____/_____ _____

_____/_____ _____

Hospitalizations: Please list any hospitalizations and approximate dates

Date (Month/Year) Location-Reason

_____/_____ _____

_____/_____ _____

SERENITY HEALTH

SOCIAL/CULTURAL HISTORY:

Which of the categories best describes your current annual Income? Please check the correct category:

☐ <$10,000 ☐ $10,000-$14,999 ☐ $15,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000-$49,999 ☐ $50,000-79999 ☐ Over $80,000

Family size* (including self) _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ White

☐ Hispanic ☐ Other Race ☐ Other Pacific islander ☐ Unreported/Refused to report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report

Veteran: ☐ Yes ☐ No

Sexual Orientation: ☐ Straight ☐ Gay or Lesbian ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose

Gender Identification: ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Other ☐ Choose Not to Disclose

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate/Professional

Current Living Situation (Check all that Apply): ☐ Single Family Household ☐ Multi-Generational Household ☐ Homeless ☐ Shelter ☐ Other

Smoking/Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/Day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/Week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐ Yes ☐ No Have you ever had a sexually transmitted disease (STD)? ☐ Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐ Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

_____

_____

_____

SERENITY HEALTH

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

☐ Alcoholism	☐ Bipolar Disorder	☐ Depression	☐ High Cholesterol	☐ Osteoporosis
☐ Anemia	☐ Cancer	☐ Diabetes (1 or 2)	☐ High Blood Pressure	☐ Stroke
☐ Asthma	☐ COPD/Emphysema	☐ DVT (Blood Clot)	☐ Kidney Disease	☐ Thyroid
☐ Arthritis	☐ Dementia	☐ Heart Disease	☐ Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

☐ Alcoholism	☐ Bipolar Disorder	☐ Depression	☐ High Cholesterol	☐ Osteoporosis
☐ Anemia	☐ Cancer	☐ Diabetes (1 or 2)	☐ High Blood Pressure	☐ Stroke
☐ Asthma	☐ COPD/Emphysema	☐ DVT (Blood Clot)	☐ Kidney Disease	☐ Thyroid
☐ Arthritis	☐ Dementia	☐ Heart Disease	☐ Migraines	

Other: _____

SIBLINGS: Brothers: _____ Sisters: _____

CHILDREN: Boys: _____ Girls: _____

Patient/Guardian Signature: _____ Date: _____

Guardians Relationship to Patient: _____ *(if applicable)*

SERENITY HEALTH

CONSENT TO TREATMENT / SERVICES

The following is to be completed and initialed by the client or client's legally authorized representative: I _____, consent to mental health treatment for myself, or _____, for whom am the parent or legally authorized representative. I understand that Serenity Mental Health/Serenity Health I ("Serenity") will share patient mental health information according to Federal and State law for treatment, payment and operations. X _____

I am aware that the type and extent of services I will receive will be determined following an assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. I am also aware that Serenity is NOT a 24-hr. crisis intervention provider and that should I be faced with a life-threatening emergency, I should call 9-1-1. X _____

Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality including the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect them and to inform the proper authorities. X _____
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provide services with SERENITY. All professionals-in-training are supervised by licensed clinicians. X _____

I am fully aware that if I seek assistance from SERENITY in accessing community resources and I request transportation from any employee of SERENITY in efforts to meet my treatment needs, in extreme cases such as auto accident or other physical errors, I release SERENITY from any and all liabilities and assume all responsibility for my personal well-being and care. X _____

I am aware that SERENITY services will be billed to my insurance company and that there may be co- pays associated with these services. I authorize my insurance provider to pay SERENITY for all services rendered. We accept Medicaid, private insurance and private pay patients on a sliding scale that qualify. It is your responsibility to verify that our health center accepts your insurance. Co-payments need to be made at the time of your appointment. We accept cash or PayPal Credit payments. If you or your child has a pending case with Medicaid or private pay, we require that you provide sliding fee documents at the time of the visit. If your child or you are approved for Medicaid, this will be reimbursed to you by our billing company. Documents you need to bring to the first appointment in order to establish care: • Picture ID-adults • Uninsured patients will have to bring proof of address (receipt of electricity, or telephone}, check stubs and/or tax return. Payment Due at Time of Services: • All co-payments and sliding fee portions are due and payable at the time of check-in. If you don't have all the criteria when applying for sliding fee discount you will be responsible to pay the full amount of the visit without a discount. X _____

I understand that it is my responsibility to sign the SERENITY consent log each time I, and/or my child, is picked up and transported outside of my home. Failure to sign this log will relieve SERENITY from any liability if you and your assigned worker do not communicate the location of or length of a session. X _____

I understand that if I have any concerns with my assigned SERENITY worker, or the services that I am receiving, that it is my responsibility to call the Quality Assurance Department at 702-815-1550 to report my concern. X _____

I have reviewed SERENITY HIPPA Policy and fully understand my rights X _____

If I have any questions regarding this consent form or about the services offered by SERENITY, I may discuss them with my therapist. **I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by SERENITY. I understand that I may stop treatment at any time.** X _____

SERENITY HEALTH

GRIEVANCE PROCEDURE

The purpose of the client grievance procedure is to allow you, as the client, the opportunity for recourse should there be unhappiness with the services provided or decisions made.

Upon initial complaint a program supervisor will conduct a preliminary investigation, and if deemed necessary by the program supervisor, or at your request; a meeting will be held with you, your worker from Serenity , and a program supervisor. The purpose of this meeting will be to resolve any dispute if possible. If the meeting is unsuccessful, Serenity will arrange for the Clinical Supervisor to hear and address your grievance. If you are not satisfied with the responses given, you may contact the State of Nevada to discuss your concern.

X _____

ATTENDANCE POLICY

Therapy is designed to reduce and/or manage symptoms. Therefore, to achieve the full effectiveness of treatment, clients are expected to fully commit to therapy services on a consistent basis. By signing below, clients confirm their agreement to attend all scheduled appointments, and arrive at the appointments on time. If for whatever reason clients are unable to keep their scheduled appointment, they're expected to give notification of the cancelation at least 1 day before the day of the appointment. "No Shows" for scheduled appointments could result in the termination of services. Termination of services will include medication management at Serenity. If clients arrive more than 15 minutes after the session start time, the therapist has the right to cancel the remainder of that appointment.

I understand that should I fail to comply with these terms, my services may be terminated. X _____

PROPER COMMUNICATION WITH THE AGENCY

I acknowledge and adhere to only contact my clinician (via phone call, text, or email) for scheduling purposes. This includes confirming, cancelling or rescheduling therapy appointments. Any questions regarding medication management, requesting medical records, etc., should be directed to the Front Desk or the appropriate department.

I understand that Serenity Mental Health provides outpatient treatment and crisis interventions specific to the treatment between a client and their clinician and is unable to provide emergency services. In the event that a client is experiencing mental health emergency they should contact emergency services (911) or locate the nearest hospital/psychiatric hospital.

X _____

ePRESCRIBE PROGRAM

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe program allows the provider to view formulary and benefit transactions, fill statuses of prescriptions, medication history within the system.

As part of this consent form, you specifically consent to the release of this and other sensitive health information that may be included within your medication history.

X _____

SERENITY HEALTH

WEAPON FREE WORKPLACE POLICY

Purpose

To ensure that Serenity maintains a workplace safe and free of violence for all employees and clients, the company prohibits the possession or use of dangerous weapons on company property.

Persons Covered

All Serenity workers and clients are subject to this provision, including contract workers and temporary employees as well as visitors and customers on company property. A license to carry the weapon on company property does not supersede company policy. Any employee and contractor in violation of this policy will be subject to disciplinary action, up to and including termination. Any client in violation of this policy will be asked to be taken off property and Serenity has the rights to cut off all services.

Definitions

"Company property" is defined as all company-owned or leased buildings and surrounding areas such as sidewalks, walkways, driveways and parking lots under the company's ownership or control. This policy applies to all company-owned or leased vehicles and all vehicles that come onto company property.

"Dangerous weapons" include firearms, explosives, knives and other weapons that might be considered dangerous or that could cause harm. Employees are responsible for making sure that any item possessed by the employee is not prohibited by this policy.

Enforcement

This policy is administered and enforced by Serenity. Anyone with questions or concerns specific to this policy should contact any of the Serenity Directors.

Patient acknowledgment:
I have read, understand, and agree to adhere to the Weapon free Workplace Policy.

_____ _____

Patient Signature Date

Updated: 12/2021

SERENITY HEALTH

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes standards to protect the privacy of healthcare information. Clients have certain rights to access and control how their healthcare information is used. Clients may request copies of their records, authorize others to receive copies of their records, request that corrections or changes be made their record, and request a list of when and to whom their health information has been shared.

"Protected healthcare information" means healthcare information (including identifying information) collected from a client or received by a provider, another provider, a health plan, employer, or healthcare clearinghouse. It may include information about a client's past, present, or future physical or mental health or condition, the provision of healthcare and payment for services.

As a client, your alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without written consent unless otherwise provided for by the regulations.

All protected healthcare information will be compiled in a client's chart, which will be kept in locked cabinets in a locked room unless being utilized by staff members responsible for the provision of clinical services. At such times, staff members are responsible for maintaining confidentiality of information in the chart.

Clients have the right to choose the healthcare/mental healthcare provider that will provide services. If at any time after selecting a provider, the client would like to change providers, HIPAA gives the client a right to do so. This is known and portability of services.

Before Serenity can disclose any healthcare information, they must obtain specific written consent to do so. Client has the right to revoke said written consent in writing at any time.

Clients have the right to review and copy their chart maintained by SERENITY, except when that information is being compiled for use in civil, criminal, or administrative proceedings. Clients have the right to review this information after giving at least 24 hours oral or written notice. The client or their legal representative has the right to receive photocopies within 48 hours of notice.

Client has the right, with some exceptions, to correct or change healthcare information maintained in their records. Clients may request and receive a list of disclosures of their health-related information created by SERENITY.

HIPAA allows the exchange of protected information with Medicare, Medicaid, Nevada Check-Up, and other private insurance companies for purpose of treatment, payment, and healthcare operations. Requests for healthcare information that will be utilized in determining eligibility for treatment or pre-authorization of payment do not require authorization from the patient/recipient for release. Federal Law permits the disclosure of your information without your written consent for the following circumstances:

- To report a crime permitted on our premises or against our personnel
- To medical personnel in a medical emergency
- For research, audit, or evaluations
- To appropriate authorities to report suspected child abuse or neglect
- As allowed by a court order

SERENITY HEALTH

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PROTECTED HEALTH INFORMATION:

In the course of treatment, information regarding your care may be created and/or received by us. Information which can be used to identify you and which relates to your past, present or future physical or mental condition, receipt of care or payment for care is considered protected information and is protected by federal and state law.

Federal law imposes certain obligations and duties upon providers of services with respect to your protected information. Specifically, we are required to:

- Provide you with notice of our legal duties and policies regarding the use and disclosure of your protected information;
- Maintain the confidentiality of your protected information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your protected information, unless under the law we are authorized to release your protected information without your authorization.
- Allow you to inspect and copy your protected information;
- Act on your request to amend protected information, although we are not required to amend the protected information, within sixty (60) days and notify you of any delay which would require us to extend the deadline by the permitted thirty (30) day extension;
- Accommodate reasonable requests to communicate protected information by alternative means or methods; and
- Abide by the terms of this notice.

HOW YOUR PROTECTED INFORMATION MAY BE USED AND DISCLOSED

Generally, your protected information may be used and disclosed by us only with your express written authorization. This written authorization includes to whom the information may be disclosed, what information may be disclosed, and for what purpose. You may revoke this authorization at any time, although any information released prior to the revocation may be used as stated on the consent.

There are some exceptions to this general rule. The following explains how we will use or disclose your protected information without your authorization:

- **Treatment Purposes:** We may use or disclose your protected information for treatment purposes to doctors, nurses, hospitals, for instance, in order to facilitate your treatment.
- **Payment Purposes:** Your protected information may be used or disclosed to your insurance company, for instance, for payment purposes as it may be necessary to disclose this information so that we may properly receive payment for treatment and services provided.
- **Health Care Operations:** Your protected information may be used or disclosed for health care operations. For example, record review related to quality assurance and improvement activities.
- **Compliance and Quality Assurance:** We may release your protected information to another individual or entity covered by the HIPPA privacy regulations that has a relationship with you for fraud and abuse detection or compliance purposes, quality assessment and improvement activities, or review, evaluation or training of professionals or students.
- **Oversight Activities:** Your protected information may be used or disclosed to an oversight agency for activities authorized by law. Examples of oversight activities include audits, investigations, and inspections. In most cases, the oversight activity will be for the purpose of overseeing services and agency compliance with certain laws and regulations.
- **Judicial and Administrative Proceedings:** If you are involved in a lawsuit or other administrative proceeding, we may release your protected information in response to a court or administrative order. We may also release protected information pursuant to a subpoena or discovery request, but only if efforts have been made by the request or to provide you with notice of the request and you have failed to object or the objection was resolved in favor disclosure, or in the alternative, the requestor has obtained a protective order protecting the requested information.
- **Law Enforcement:** We may release your protected information to law enforcement officials when required or permitted by federal or state law to do so.

- **Emergency Circumstances:** Protected information may be disclosed to personnel who have a need for information about a client, such as for the purpose of treating a medical or mental condition which poses an immediate threat to the health and safety of any individual or the public and which requires immediate intervention.
- **Individuals Involved in Your Care:** We may give out your protected information to a friend or family member who is helping with your care or with payment for your care. However, prior to sharing your protected information in this instance we will first attempt to obtain your verbal or written consent. An example of when obtaining such consent would not be feasible would be if you are involved in a serious accident and unavailable to give your consent and it is necessary for us to speak with your emergency contact or other responsible party.
- **Mandatory Reporting of Child Abuse/Dependent Adult Abuse:** Serenity's staff are mandatory reporters of child abuse and dependent adult abuse. If there is reason to suspect that child abuse or dependent adult abuse has occurred, your protected information may be disclosed as required by law.
- **As Authorized by Law:** We will disclose your protected information for reasons not described above when required by law to do so.
- **More Stringent Laws:** Some of your protected information may be subject to other laws and regulations and are afforded greater protection that what is outlined in this Notice. For instance, HIV/AIDS, substance abuse, and mental health is often given more protection. In the event your protected information is afforded greater protection under federal or state law, we will comply with applicable law.

YOUR RIGHTS

Federal law grants you certain rights with respect to your protected information. Specifically, you have the right to:

- Receive notice of our policies and procedures used to protect your protected information.
- Request that certain uses and disclosures of your protected information be restricted, provided, however, if we release the information without your consent or authorization, we have the right to refuse your request.
- Access to your protected information be amended, although we are not required to grant your request.
- Obtain an accounting of certain disclosures by us of your protected information for the past six (6) years.
- Revoke any prior authorizations for use or disclosure of protected information, except to the extent that action has already been taken; and
- Request that communications of your protected information are done by alternative means or at alternative locations.

IMPORTANT CONTACT INFORMATION

This notice has been provided to you as a summary or how we will use your protected information and what your rights with respect to your protected information are. If you have any questions or would like more information regarding your protected information, please contact your direct worker or the supervisor of the program in which you participate. If you believe your privacy rights have been violated, you may file a complaint with our office by contacting your direct worker or the supervisor or the program in which you participate. He or she will provide you with specific information regarding the agency's grievance policy. You may also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for the filing of a complaint.

SERENITY HEALTH

CLIENT RIGHTS FOR THOSE SEEKING MENTAL HEALTH TREATMENT:

☐ Not Applicable

The following applies to all clients of our counseling and mental health services: The client has the right:

A) To choose a healthcare provider that is approved by their insurance provider to provide services.

B) To care and treatment that is considerate and respectful of their personal values and belief systems.

C) To be treated with dignity, consideration, and respect at all times.

D) To reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age or disability.

E) To expect quality service provided by concerned, trained, professional and competent staff.

F) To expect complete confidentiality within the limits of the law, and to be informed about the legal exceptions to confidentiality, and to expect that no information will be released without the client's knowledge and written consent.

G) To participate in an informed way in the decision-making process regarding their treatment planning.

H) To a clear working contract in which business items, such as time of sessions, payment plans/ fees, absences, access, emergency procedures, and third-party reimbursement procedures are discussed.

I) To a clear statement of the purposes, goals, techniques, rules of procedure and limitations, as well as the potential dangers of the services to be performed, and all other information related or likely to affect the ongoing mental health counseling relationship.

J) To appropriate information regarding the mental health counselor's education, training, skills license and practice limitation and to request and receive referrals to other clinicians when appropriate.

K) To full, knowledgeable, and responsible participation in the ongoing treatment plan to the maximum extent feasible.

L) To obtain information about case records and to have this information explained clearly and directly.

M)To request information and/or consultation regarding the conduct and progress of therapy.

N) To refuse any recommended services and to be advised of the consequences of this action.

O) To a safe environment free of emotional, physical and sexual abuse.

P) To a client grievance procedure, including requests for consultation and/or mediation, and to file a complaint with the mental health counselor's supervisor, and/or the appropriate credentialing body; and

Q) To a clearly defined ending process, and to discontinue therapy at any time.

Patient acknowledgment:

I have read, understand, and have been provided a copy of the above Patient's Rights.

_____ _____

Patient Signature Date

Updated: 12/2021

SERENITY HEALTH

CLIENT RIGHTS FOR THOSE SEEKING SUBSTANCE USE TREATMENT:

☐ Not Applicable

As the patient of a program for treatment of abuse of/or dependency upon alcohol or other drugs, your rights include, but are not limited to, the following:

A) If the program receives funds from the Substance Abuse Prevention and Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether or not you can afford to pay for it, and the program is prohibited from imposing any fee or contract, which would be a hardship for you or your family.

B) You have the right to be provided treatment appropriate to your needs.

C) If you are transferred to another treatment provider, you have the right to be explained the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.

D) You have the right to be informed of all program services, which may be of benefit to your treatment.

E) You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.

F) You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of staff involved in your treatment.

G) You have the right to be informed of our diagnosis, treatment plan and prognosis.

H) You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimated cost of treatment, and a description of the alternatives to treatment.

I) You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.

J) You have the right to examine your bill for treatment and to receive an explanation of the bill.

K) You have the right to be informed of the program's rules for your conduct at the facility.

L) You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.

M) You have the right to receive respectful and considerate care.

N) You have the right to receive continuous care: To be informed of our appointments for treatment, the names of program staff available for treatment, and of any need for continuing care.

O) You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so.

P) You have the right to safe, Healthful, and comfortable accommodations.

Q) You have the right to confidential treatment. This means that, other than exceptions defined by law, such as those in which public safety takes priority, without your explicit consent to do so the program may release no information about you, including confirmation or denial that your are a patient. R) Waiver of any civil or other right protected by law cannot be required as a condition of program services.

S) You have the right to freedom from emotional, physical, intellectual, or sexual harassment or abuse.

T) You have the right to attend religious activities of your choice, including visitation from a spiritual counselor to the extent that such activities do not conflict with program activities. The program shall make a reasonable accommodation to your chosen religious activities. Attendance at and participation in any religious activity is to be only on a voluntary basis.

U) You have the right to grieve actions and decisions of facility staff, which you believe, are inappropriate, including but not limited to actions and decisions, which you believe violate your rights as a patient. The facility is obligated to develop a grievance procedure for timely resolution of complaints from patients and to post such a procedure in a place where it shall be immediately available to you. You have the right to freedom from retaliation or other adverse consequences as the product of filing a grievance.

V) You have the right to file a complaint with the State of Nevada if the facility's grievance procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution or other adverse consequences as the product of filing a complaint. Such complaints may be addressed in writing or by telephone to: Substance Abuse Prevention and Treatment Agency, 4126 Technology Way, 2nd Floor, Carson City, Nevada 89706. Phone: 1-775-684-4190

W) You have the right to be informed of your rights as a patient. The foregoing is to be posted in the facility in a place where they are immediately available to you, and you are to be informed of these rights and given a listing of them as soon as is practically possible upon you beginning treatment.

Patient acknowledgment:

I have read, understand, and have been provided a copy of the above Patient's Rights.

_____ _____

Patient Signature Date

TO BE COMPLETED BY THOSE SEEKING SUBSTANCE USE TREATMENT: ☐ Not Applicable

Updated: 12/2021

SERENITY HEALTH

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts repeatedly?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

SERENITY HEALTH

PATIENT / CLIENT RIGHTS/ ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of the Notice of Privacy Practices and Client Rights which summarizes the ways my identifiable health information may be used and disclosed by this provider, and it also states my rights with respect to my medical information as provided by 42 CFR. Part 2 and 45 CFR. I understand this provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event this provider revises its information practices, a revised Notice of Privacy Practices will be posted at Serenity's locations. The Serenity locations are: 1909 S. Jones Blvd Las Vegas, NV 89146 / 2280 East Calvada Suite #301-Pahrump, NV 89048 / 755 N. Roop St Ste. 101 Carson City, NV 89701. S I may obtain a current form at any time from any Serenity location.

CHILD/DEPENDENT ADULT ABUSE REPORTING POLICY

It is our duty, as mandatory reporters, to immediately report any suspected child abuse to Child Protective Services. The worker shall report suspected abuse orally to the CPS, followed by a written report to CPS within 48 hours after such oral report. The worker shall also make an oral report to an appropriate law enforcement agency if the worker believes that immediate protection of the child is advisable.

Type of abuse

1. Physical Abuse
2. Mental Injury
3. Sexual Abuse
4. Denial of Critical Care
5. Child Prostitution
6. Presence Of Illegal Drugs In The Body Of A Child
7. Manufacture Or Possession Of Dangerous Substances In The Presence Of The Child
8. Bestiality In The Presence Of A Minor
9. Cohabitation With A Registered Sex Offender

Your records cannot be released to any other individual without your written consent. However, certain information may be released without your authorization under the following legal circumstance: *When Juvenile Court is involved; records may be shared with Juvenile Court Officers. Information about a child may be shared with the child's Guardian Ad Litem. Information may also be shared in the event of a legitimate subpoena for court appearance, in the event of a medical emergency, or when the receipt of information suggests that child abuse or neglect has occurred.* SERENITY *is legally obligated to report any such information to CPS under circumstances in which there exists a danger to the child or others.*

These policies have been explained to me in my own language.

X _____ Date: _____

Patient / Client /Conservator or Legal Guardian*

X _____ Date: _____

Power of Attorney (if applicable)*

X _____ Date: _____

Witness (Only required if client signs with a mark)