Workforce Solutions for Tarrant County

Services provided under arrangement with Guinn Healthcare Technologies, LLC

Client Demographic Information, Consents and Acknowledgments

Last Name	First Name	MI	Date of Birth	Soc. Sec. #
			___/___/_____	_____-___-_____

Gender	Citizenship	Race		Ethnicity
□ Male □ Female	□ U.S. Citizen □ Permanent Residence □ Refugee □ Other	□ American Indian □ Alaskan Native □ Asian □ Asian - Indian	□ Black/African American □ Native Hawaiian □ Pacific Islander □ White	□ non-Hispanic/Latino □ Hispanic/Latino

Current Address	Preferred Phone #	Alternate Phone #

City	State	Zip Code	Email Address
	TX		

Marital Status		Family Status	Number in Household	Dependents (under 18)
□ Single □ Married □ Separated	□ Divorced □ Widowed □ Cohabitating	□ Parent in One-Parent Family □ Parent in Two Parent Family □ Other Family Member □ Not a Family Member □ N/A	_____	_____

Last grade completed in School?		Disability Status	Employment Status
□ No schooling □ Nursery to 4th □ 5th or 6th □ 7th or 8th □ 9th □ 10th □ 11th	□ 12th: no diploma □ High Sch Grad □ GED □ 1-2 year college/trade □ 3-4 year college □ Bachelors □ Masters	□ None □ Disabled - Developmental □ Disabled - Mental □ Disabled - Other □ Disabled - Physical □ Disabled Veteran	□ Full Time □ Part Time □ Searching □ Training □ Disabled □ Not seeking employment

Primary Language	Military	Military Branch		VA Discharge Status	
_____	□ Yes □ No	□ N/A □ Army □ Navy	□ Air Force □ Marines	□ Honorable □ General □ Medical	□ Bad conduct □ Dishonorable □ Other

Funding/Payment Source

□ TANF Choices
□ WIA
□ WIA - Dislocated
□ WIA – TAA
□ WF - Statewide
□ Other

Permission to Contact Me:

I grant permission to GHT staff to contact me as follows (Check all that apply):

□ By phone & leave a message on voicemail if no answer □ By leaving a message with anyone who answers my phone
□ By email

Stop here; staff will assist you in completing the remainder of this form.

Staff Use Only	GHT, LLC Client Case #:		Funding Stream	Medicaid or Ins #:
	Initial Assmt Date	Staff Name	Staff Credentials	Staff ID
	GHT, LLC Client Case #:		Funding Stream	Medicaid or Ins #:

Section A: Informed Consent to Behavioral Health Treatment and Procedures

You have the right as a patient to be informed about your condition and give your consent to treatment. In order to consent to treatment you must be an adult (age 18 or over or have the "disabilities of minor" removed) and have the ability to understand and appreciate the nature and consequences of a decision regarding behavioral health treatment and the ability to reach an informed decision in the matter. You have participated in an initial interview, screening and/or assessment for social, emotional and psychological conditions and discussed the findings with your counselor. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. **Condition:** My counselor has explained to me that I appear to have condition(s) symptomatic of a mental disorder.

2. **Proposed Procedure(s):** I understand that the procedure(s) proposed for evaluating and treating my condition is/are: participation in a clinical interview and structured diagnostic assessment to further define the need or problems to be addressed, and potentially participation in one or more of the following activities: counseling sessions, case management, peer support, treatment/case management planning sessions, activities designed to assist me in achieving self sufficiency and/or permanent housing or other outcomes.

3. **Risks/Benefits of Proposed Procedure(s):**
   - **A.** Some of the potential benefits of the treatment and procedures proposed are: Improved mood, improved ability to function in important social relationships, improved ability to achieve self sufficiency and stable housing, improved ability to cope with stress, reduced emotional distress, improved access to supports and services.
   - **B.** Just as there may be benefits to the proposed treatment and procedures, I also understand the recommended treatment and procedures involve risks. These risks include recalling or re-experiencing unpleasant memories and feelings, the possibility of increased stress related to participating in counseling, the possibility that my need for treatment may be more long-term than the program can provide, I could be involved in an auto accident or other accident if I am being provided transportation assistance from program staff, the confidentiality of my circumstances or treatment could be inadvertently revealed.

4. **Complications; Unforeseen Conditions; Results:** I am aware that in the practice of counseling, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed treatment and procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

5. **Acknowledgments:** The available alternatives, some of which include psychiatric treatment with medication, peer support or other non-professional assistance; assistance in a faith based support program may provide some of the same benefits. The benefits of these alternatives in a less structured approach to treatment and the potential for longer term involvement. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

6. **Consent to Procedure(s) and Treatment:** Having read this form and talked with the counselors and case managers, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above by my counselor and/or his/her trained associates.

Section B: Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices
By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Guinn Healthcare Technologies, LLC (GHT, LLC). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by making a request to your health care team.

Section C: Treatment Plan/Planning and Participation

Acknowledgement of Participation in Treatment Planning
By signing this form, you acknowledge that your counselor had discussed with you an initial plan of treatment, and that your participation in treatment is voluntary. You and your counselor may develop a more detailed plan at a future date if your case requires it. You further acknowledge that you are in agreement with the plan and that you understand that you may request to modify the plan at any time. Your request to modify the plan will be honored to the extent possible and practical within guidelines. In the event we are not able to meet your request for a changed plan of services, we will inform you of our limitations and refer you to other assistance as possible.

Section D: Acknowledgment and Consents

Permission to contact you

_____ *Section A:* I acknowledge providing voluntary general consent to behavioral health treatment and procedures.
Initials
_____ *Section B:* I acknowledge receipt of the *Notice of Privacy Practices* of GHT, LLC.
Initials
_____ *Section C:* I acknowledge participation in treatment planning.
Initials
_____ *Permission to Contact Me:* I grant permission to contact me as listed on the Demographic Sheet for GHT, LLC.
Initials

_____ _____
CLIENT SIGNATURE (or parent/guardian for minor) DATE

_____
CLIENT SOCIAL SECURITY #

_____ _____
STAFF SIGNATURE DATE

Guinn Healthcare Technologies, LLC

Authorization to Release Confidential Information

I authorize Guinn Healthcare Technologies, LLC to disclose to and receive from:

☒ Person/organization: (List name, address)

Workforce Solutions for Tarrant County
(Main Office and/or Career OneStop Centers)
1320 S. University Dr. Ste 600
Fort Worth, TX 76107

☐ Person/organization: (List name, address)

the following information:

☒ my name and other personal identifying Information
☒ initial evaluation
☒ date of admission
☒ assessment results
☒ summary of treatment plan
☐ Other: (list)
_____

☒ progress and compliance with treatment attendance
☒ date of discharge and discharge status
☒ discharge plan
☒ employment and training related information

The purpose of these disclosures is to enable the identified entities to provide or receive information related to assisting with treatment, evaluating and responding to participation and progress, determining my readiness/ability to participate in work, or other purposes. [Other: describe: _____]

For Substance Abuse Clients: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- upon my termination from Guinn Healthcare Technologies, LLC Mental Health and Social Services Programs or three years from the date this consent is signed (whichever comes first)

For Mental Health Clients: I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- upon my termination from Guinn Healthcare Technologies, LLC Mental Health and Social Services Programs or three years from the date this consent is signed (whichever comes first)

_____ _____
CLIENT SIGNATURE DATE

_____
CLIENT SOCIAL SECURITY #

_____ _____
STAFF SIGNATURE DATE

_____
END DATE (consents will expire 3 years from the date of client signature unless otherwise indicated)

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.