Please complete these forms prior to your scheduled encounter.

Enter the following information and it will automatically be entered onto successive pages. You won't have to type this information again.

Each of these fields are mandatory:

First Name (patient) & MI _____

Last Name (patient) _____

Social Security Number _____

Date of Birth & Age _____

Today's date _____

Patient's full name _____

When you have completed the packet of forms, please save the file adding your name to the file name, then email it to outpatient@parksideinc.org, or you can fax it to 918-588-8860, or call us at 918-582-2131 to make arrangement to drop it off or mail it in.

The next page pertains to adults. If the patient is a child, skip the next page and go to the third page.

Patient Information - Adult

Please provide us with the current information below so that we can keep your file accurate and up-to-date. We request that you please print the information legibly. Thank you for your cooperation.

Patient Information:

MRN#: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Social Security #: _____ Sex : M ☐ F ☐

Current Mailing Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
Please include area codes. *Please include area codes.* *Please include area codes.*

Marital Status (circle one): Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Life Partner ☐

Maiden Name (If Applicable)_____

Race: ___White/Caucasian ___African American ___Native American ___Alaskan Native ___Asian ___Hispanic/Latino ___Non-Hispanic/Latino ___Pacific Islander ___Other Not Listed

Ethnicity: ___Mexican ___Puerto Rican ___Cuban ___Other Hispanic ___Not Hispanic ___African American ___Native American ___White/Caucasian ___African ___European ___Other Not Listed ___Unknown

Spouse/Significant Other or Emergency Contact:

Last Name: _____ First Name: _____

Relationship to Client: _____

Current Mailing Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
Please include area codes. *Please include area codes.* *Please include area codes.*

For Adults with a Legal Guardian: Legal Guardian Information

Last Name: _____ First Name: _____

Relationship to Client: _____

Current Mailing Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
Please include area codes. *Please include area codes.* *Please include area codes.*

For Adults with a Payee: Payee Contact Information:

Last Name: _____ First Name: _____

Current Mailing Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
Please include area codes. *Please include area codes.* *Please include area codes.*

Signature:_____ Date:_____

Parkside
Psychiatric Hospital & Clinic

Patient Information - Youth

Please provide us with the current information below so that we can keep your file accurate and up-to-date. We request that you please print the information legibly. Thank you for your cooperation.

MRN#: _____

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Social Security #: _____ Sex : M ☐ F ☐

Marital Status (circle one): Married Single Divorced Widowed Legally Separated Life Partner

Maiden Name (If Applicable)_____

Race: ___White/Caucasian ___African American ___Native American ___Alaskan Native ___Asian ___Hispanic/Latino ___Non-Hispanic/Latino ___Pacific Islander ___Other Not Listed

Ethnicity: ___Mexican ___Puerto Rican ___Cuban ___Other Hispanic ___Not Hispanic ___African American ___Native American ___White/Caucasian ___African ___European ___Other Not Listed ___Unknown

Parent/Legal Guardian Information:

Last Name: _____ First Name: _____

Relationship to Client: _____ SSN: _____ DOB: _____

Current Mailing Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
Please include area codes. *Please include area codes.* *Please include area codes.*

Emergency Contact:

Last Name: _____ First Name: _____

Relationship to Client: _____

Current Mailing Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
Please include area codes. *Please include area codes.* *Please include area codes.*

If there is another biological, adoptive, or legal parent/guardian, please provide their information with a note about their legal rights.

Other Parent/Guardian Information:

Last Name: _____ First Name: _____

Relationship to Client: _____ SSN: _____ DOB: _____

Current Mailing Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
Please include area codes. *Please include area codes.* *Please include area codes.*

Describe their legal rights concerning the minor: _____

Signature:_____ Date:_____

Parkside
Psychiatric Hospital & Clinic

Financial Information

MRN#: _____

Patient Name: _____ DOB: _____ SSN: _____

Medicaid

Policy#: _____

Annual Household Income: _____

Total Household Size: _____

Medicare

Policy#: _____

Name on Card: _____

Private Insurance Information: *To verify benefits and file claims, all information below must be provided.*

Insurance Company: _____ Phone: _____
Please include area code.

Subscriber Last Name: _____ First Name: _____ MI: _____

Subsciber's SS#: _____ Date of Birth: _____ Relationship to Client: _____

Policy#: _____ Group#: _____ Group Name: _____

Employer Name: _____ Employer Phone#: _____

Other Insurance Information: (If applicable)

Insurance Company: _____ Phone: _____
Please include area code.

Subscriber Last Name: _____ First Name: _____ MI: _____

Subsciber's SS#: _____ Date of Birth: _____ Relationship to Client: _____

Policy#: _____ Group#: _____ Group Name: _____

Employer Name: _____ Employer Phone#: _____
Please include area code.

Other Insurance Information: (If applicable)

Insurance Company: _____ Phone: _____
Please include area code.

Subscriber Last Name: _____ First Name: _____ MI: _____

Subsciber's SS#: _____ Date of Birth: _____ Relationship to Client: _____

Policy#: _____ Group#: _____ Group Name: _____

Employer Name: _____ Employer Phone#: _____
Please include area code.

☐ Self Pay. No Insurance Coverage.

Signature:_____ Date:_____

Financial Assistance

Parkside would like to assist our patients with every opportunity to provide financial assistance for Inpatient services provided to you or your family member**. If you or your family member has no coverage through Medicare, SoonerCare (Medicaid), and/or a commercial insurance we request that you please provide us with your income information in order for us to determine if you qualify for financial assistance.** Once we have verified your income we will then make recommendations for a discount based on a sliding fee schedule. *(Please print all information)*

Person's Name Applying for Financial Assistance: _____

Social Security Number: _____

How many family members are in your household? _____

What is your current monthly gross income? $_____ *(Income before taxes)*

Address used to file last year's taxes: _____

_____

SoonerCare (Medicaid):

If your child is 18 years old or under, they may qualify for SoonerCare based on the income guidelines below. If the child does not receive SSI and/or disability benefits you may apply online at www.mysoonercare.org. However, if they do have SSI and/or disability benefits you will need to apply at your county DHS office. You must be a US citizen and Oklahoma resident to qualify for benefits through the SoonerCare program**.**

If you wish to apply for SoonerCare we must have the client/patient's Social Security Number and Date of Birth to establish the effective date of eligibility and to cover services provided by Parkside from the date of admit. Please make sure this information is provided on the first page of this form.

Size of Household	Monthly Income	Annual Income
1	$2,079	$24,948
2	$2,804	$33,648
3	$3,528	$42,336
4	$4,253	$51,036
5	$4,977	$59,724
6	$5,702	$68,424
7	$6,428	$77,136
8	$7,157	$85,884

Yes or No I will be applying for SoonerCare within 24-48 hours from the date of admission.
If YES, please provide the information below:

How many family members are in your household? _____

What is your current monthly gross income? $_____
(Income before taxes)

We would be happy to assist you in your application, if you need assistance with the online application please contact the Business Office at 918-588-8850. You may also contact SoonerCare directly if you have more specific questions about the program & enrollment at 800-987-7767.

Think your income may be a little over the income guidelines above? Apply anyway, some applicants qualify for SoonerCare with slightly higher incomes. This is also a great supplement to any commercial insurance you may have.

Signature:_____ Date:_____

PATIENT RIGHTS AND RESPONSIBILITIES

Parkside considers you a partner in your health care and we encourage you to participate actively in your treatment decisions. We believe if you are well-informed and communicate openly with your physician and other health professionals, your care will be more effective and you will live a healthier and happier life. We encourage respect for the personal preferences and values of each individual. Teamwork between our patients and staff is essential for success. Our policies and practices address your rights as a patient for treatment, care, and services within the capability and mission of Parkside and in compliance with law and regulation.

PATIENT RIGHTS

As a patient, you have the following rights:

1. To receive a copy of the Patient handbook, which includes any rules or regulations of Parkside that apply to your conduct as a patient.
2. To have additional information about and/or implementation of advance directives for healthcare as described in the Parkside policy and procedure.
3. To be treated with dignity and to have your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.
4. To have quality and ethical treatment, regardless of sex, race, religion, color, national origin, sexual orientation, gender identity/expression, source of payment for care, or nature and severity of a handicapping condition.
5. You have the right to have regular opportunity to engage in age appropriate or developmentally appropriate activities.
6. To receive services suited to your condition in a safe, sanitary environment.
7. To be safe from mental, physical, sexual and verbal abuse, neglect, harm, and exploitation.
8. To receive treatment in the least restrictive environment consistent with your safety and legal status.
9. To have freedom from restraint or seclusion that is not medically necessary or punitively administered.
10. To receive proper pain management.
11. To have privacy during your treatment as safety permits.
12. To maintain all records and communications in a confidential manner. Information regarding your treatment or records will only be released with you or your legal guardian's written authorization, as required under proper legal direction, or as explained in the HIPAA Privacy Notice.
13. To have access, request amendment to, and receive an accounting of disclosures regarding your clinical service information as permitted by law.
14. To receive information about the nature of your care, procedures, and treatment and to participate in decisions regarding your care and treatment. You have the right to an explanation of the risks, side effects, and/or benefits of any medication or treatment that is recommended. You also have the right to be informed of any alternative treatment procedures that are available.
15. To know the name, specialty, and other information about the person responsible for your care or the coordination of your care. This includes your right to know of the existence

of any professional relationship among individuals who are treating you, as well as their relationship to any other health care or educational institution involved in your care.

16. To be informed of any proposed changes with staff responsible for your care or for any transfer of your care either inside or outside of Parkside.
17. To receive reasonable continuity of care including source, information, and instructions upon discharge from the facility.
18. To be involved in resolving problems about care, treatment, and services.
19. To refuse treatment except in emergency situations. If you do refuse treatment, you have the right to be informed about the responsibility of Parkside to seek appropriate legal alternatives, or in accordance with professional standards, to terminate the relationship with you upon reasonable notice.
20. To refuse to participate in any research project or medical experiment without your informed consent as defined by law. Refusal to participate shall not affect the services available to you.
21. To request the opinion of a consultant at your own expense.
22. To request an in-house review of your care, treatment, and treatment plan.
23. To receive an explanation of the charges and services on billing documents.
24. To contact a relative, friend, personal physician, clergyman, or an attorney under reasonable conditions. You may also contact a patient representative selected for decision-making as needed.
25. To voice complaints or grievances and with a written option to appeal any decisions made. You have the right to request information about Parkside's mechanisms for the initiation, review, and resolution of patient complaints. If you wish to communicate a concern or grievance, please contact any staff member who would be happy to assist you. If your concerns are not addressed to your satisfaction, you may call the Grievance Coordinator/Grievance Officer at (918) 586-4233. If you prefer not to call either of these people or are unhappy with the response, you may call any one of the following agencies.

Tyler Doane – Parkside Grievance Coordinator
Phone: (918) 586-4233
Email: tdoane@parksideinc.org

Address: 1220 South Trenton, Tulsa, OK 74120

The Joint Commission – 1-800-994-6640 or 1-630-792-5636
Office of Quality Monitoring
The Joint Commission
One Renaissance Blvd.
Oak Brook Terrace, IL. 30181

The Oklahoma State Department of Health – David Shenold, 405-271-6576
Medical Facilities
Protective Health Services
1000 NE 10th Street
Oklahoma City, OK 73117

Centers for Medicaid and Medicare Services (CMS) – Dallas Regional Office
Gerardo Ortiz – 214-767-6300 or RODALD@cms.jjs.gov

Oklahoma Department of Human Services – OKDHS – 1-405-521-3646
P.O. Box 25352
Oklahoma City, OK 73125

Child Abuse Hotline – 1-800-522-3511 or 1-800-422-4453

Office of Client Advocacy (OCA) 1-405-5255-4850
P.O. Box 25352
Oklahoma City, OK 73125

Adult Protective Services – 8a – 5p (918) 430-2300; after hours – 1-800-522-3511

The Oklahoma Quality Initiative Organization: 405-840-3511
Oklahoma Foundation of Medical Quality (OFMQ)
14000 Quality Sprints Parkway # 400
Oklahoma City, OK 73134

Oklahoma Commission on Children and Youth
1111 N. Lee Ave., Suite 500
Oklahoma City, OK 73103
1-866-335-9288

PATIENT RESPONSIBILITIES

As a patient, you have the following responsibilities:

1. To provide accurate and complete information about your present complaints, past illnesses, hospitalizations, medication, and other matter relating to your health to the best of your ability and knowledge.
2. To report perceived risks in care and changes in your condition or symptoms.
3. To ask questions when you do not understand your recommended care or treatment or what is expected of you.
4. To identify and communicate problems.
5. To follow instructions of nurses and other professionals who are carrying out physician orders. You are expected to express any concerns about your ability to follow care, treatment, and services.
6. To be in control of your behavior as much as possible.
7. To give and receive feedback in a courteous and respectful manner.
8. To keep all matters discussed in the program confidential, including the identity of other patients.
9. To attend program activities and follow the treatment plan and aftercare plans. If treatment is refused, to be responsible for you own actions.

10. To keep appointments.
11. To follow facility rules and regulations affecting patient care and conduct.
12. To be respectful of other patients and staff and be careful regarding your personal property, facility property, and the property of other persons in the facility.
13. To meet the financial obligations for your care and treatment as promptly as possible.
14. To inform your clinician/primary provider of a change of name, address, and ability to pay for services.

Patient Signature	Date
Parent/Guardian Signature	Date
Staff Signature	Date

Parkside
Psychiatric Hospital & Clinic

The Outpatient Team at Parkside considers it a privilege to serve you. We have made a list of our most commonly asked questions and they are addressed below. Please take a few moments to read the information and we're glad to answer any questions you may have. Your full participation in treatment will produce the best results so please sign and return this form to the Front Desk staff with any other paperwork you have been asked to complete. Thank you.

1. Please keep appointments as scheduled. When you need to reschedule any appointment please give at least 24-hour notice so we are able to let someone else benefit from the appointment time. For Monday appointments please reschedule before the preceding Friday at 10:00am whenever possible so that other people have a chance to take the appointment.
2. Appointments are considered "Failed" appointments if you are a 'no call, no show' or are cancelling without giving the required 24-hour notice. For 'no call, no show' situations, subsequent appointments with all providers will be cancelled. For any 'failed' appointments, only one appointment can be made at a time after any appointment is 'failed'.
3. We know that anyone can have an emergency. However, please know that if you 'fail' more than one Outpatient appointment we may have to give you referral information for services outside of Parkside.
4. Copayments are due at time of service. If you determine you are unable to make your copay you are asked to contact us well ahead of your appointment so we can help you identify a method of payment or reschedule with you according to your needs.
5. Parkside staff will not initiate nor perpetuate the use of Benzodiazepines (such as Xanax, Klonopin, Valium, Ativan). We won't prescribe opioids (such as Vicodin, OxyContin, Percocet, Demerol, Darvon, Lortab, Morphine, etc.) for patients. If that will be a barrier for you please let us know right away so we can discuss this important issue.
6. Parkside staff will not initiate stimulants for adult patients and only for youth after a careful, thorough assessment for ADD or ADHD.
7. Please know that the misuse of prescribed medications or refusing to take medically-necessary medications will result in your medication prescriber working with you for a plan of safety.
8. The persistent abuse of alcohol, use of illicit drugs or unapproved prescription medications will result in referrals for In-patient services, Chemical Dependency Intensive Outpatient treatment (CDIOP), or other services rather than Parkside outpatient services. Your safety is our first priority.
9. We ask that you see a Primary Care Physician (PCP) at least one time per year to ensure you have the best physical health possible. If you don't have a PCP please discuss referral options with your therapist or your medication specialist at Parkside.
10. Threats of violence toward Parkside staff, other patients, visitors, or property will result in immediate termination of services. Our environment has to be safe for everyone.
11. Your therapist will work with you to develop a 'Treatment Plan' of your goals for treatment. If you feel at any point that you are not working well with your therapist or medication prescriber please let them know. All of our staff will want your feedback so they can work through any challenges with you.
12. If for any reason you have difficulty resolving challenges with your therapist, medication prescriber, or any other staff please ask for the Director of Outpatient Services who will assist you. We also have a formal "Grievance" process that can be initiated with a simple form that is available from any outpatient staff or Parkside employee. You can also write concerns on any sheet of paper.
13. The number to the Front Desk for making Outpatient appointments is 918-582-2131. They are available Monday through Friday, 8:00am through 5:00pm excluding holidays.
14. **URGENT SITUATIONS/ EMERGENCIES:** Between your Outpatient appointments at Parkside, if your medical situation becomes urgent please call 911 or go to your nearest emergency room. If your mental health situation becomes urgent please call Parkside's Assessment & Referral line at 918-588-8888. They are available 24-7 to serve you. We count it a privilege to serve you.

I have read and understood this information:

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

INFORMED CONSENT FOR TREATMENT

Patient Label

TREATMENT:
I, the undersigned patient, both personally or through the person legally empowered to sign this consent and obligate me as herein contemplated, request and authorize Parkside, Inc., its employees, agents, affiliates (jointly and separately), and physicians to provide hospital care (acute care, residential care, or any of the outpatient programs), upon admission therein, including without limitation, physical examination, routine diagnostic procedures and medical or psychological treatment which is to include whatever procedures that are deemed necessary by the admitting physician and such other physician, assistants, students, or volunteers as s/he may designate.

I summarily request and authorize Parkside, Inc. and physician(s) to administer any treatment and perform such other actions as the physician may deem necessary or advisable in the diagnosis and treatment of my illness. If indicated or requested, and with proper written consent, testing for communicable diseases will be performed on physician order.

I am aware that the practice of medicine is not an exact science and acknowledge that no warranty, guarantee or assurance has been made thereto by hospital and/or physician as to the result of treatments, examinations or otherwise that may be obtained.

RESTRAINT, SECLUSION, PHYSICIAL HOLDS AND TIME OUTS:
Parkside, Inc. reserves the right to restrain, seclude or physically hold any patient clinically determined to be a risk to him/herself or others. Restraints, seclusions and physical holds are performed by physician order consistent with hospital policy and procedure. A patient may request to take a time out or may be asked by a staff member to take a time out if he/she is disrupting the milieu or needs time to regain control of his/her behavior. Time outs do not require a physician's order and may not exceed thirty (30) minutes duration.

CONFIDENTIALITY & DISCLOSURE OF INFORMATION:
Parkside, Inc. will honor and respect my protected health information rights according to state and federal laws and the *Notice of Privacy Practices.* I understand that my medical records and billing information are made and retained by Parkside, Inc. and are accessible to hospital personnel and medical staff. Hospital personnel and physicians in attendance may use and disclose medical information for hospital operations and functions to any other physician or health care personnel involved in my continuum of care for this admission. Safeguards are in place to discourage improper access. Parkside, Inc. and its medical staff are authorized to disclose all or part of my medical record to any insurance provider who is or may become involved with my care. Oklahoma law requires that Parkside, Inc. advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphills, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS**).** Communicable diseases will be released to health authorities as required by law.

FINANCIAL RESPONSIBILITY:
1. As consideration for the services provided me, payment is guaranteed for any amount due for such servicesprovided by Parkside, Inc. Hospital charges for services and goods shall be at Parkside, Inc.'s billed charges rates unless otherwise agreed to in writing by Parkside, Inc. Amounts estimated or known to be payable by me become due and payable at the time of discharge including, but not limited to, health insurance deductible and coinsuranceamount(s).
2. I understand that Parkside, Inc. will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment. I understand that any requirement for completion of insurance precertification is the responsibility of the policyholder.

3. I agree that insurance benefits for Parkside, Inc. charges payable to the insured are to be made payable to Parkside, Inc. and that physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. I understand that I am responsible for any charges not covered by this assignment. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.
4. I agree to comply with all hospital rules and regulations and to participate in the treatment program as prescribed. I agree to reimburse Parkside, Inc. for any damage to the facility or personal property that I may cause or a patient for whom I am legal guardian my cause during the course of treatment.

TELEHEALTH ENCOUNTERS INFORMED CONSENT:

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of providing patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: patient medical records, and live two-way audio and video communication. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Records of the telehealth encounter will be entered into Parkside's electronic medical record keeping system and are available from Parkside's Health Information Management department in accord with regular medical records policy.

Expected Benefits: improved access to care, decreased need for travel, more efficient evaluation, obtaining the expertise of a specialist.

Possible Risks: telehealth encounter failure due to equipment or connection failure, in very rare instances, security protocols could fail or partially fail causing a possible breach of personal health information.

Upon providing your electronic signature, you acknowledge that you understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand the alternatives to telemedicine consultation.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
6. I understand that portions of my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. Health care information transmitted is documented and retained as medical records and is available to the patient. Dissemination to other entities or persons external to the patient practitioner relationship will not occur without written consent of the patient. Parkside maintains no video or recordings of the telehealth encounter.

PERSONAL BELONGINGS & RELEASE OF RESPONSIBILITY:

1. Parkside, Inc. is hereby released from any responsibility for personal property I do not provide to it for safekeeping.
2. I acknowledge that Parkside, Inc., or employees thereof, shall not be responsible for any personal valuables or belongings including, but not limited to, glasses, dentures, hearing or other prosthetic devices retained on my person or left in any room during my treatment.

3. Parkside Inc. is held harmless from any injuries, damages, claims or actions that may arise out of my use of personal equipment.

INPATIENT TREATMENT ONLY:

1. I consent to observation and diagnosis for inpatient hospital evaluation and treatment. Care and treatment includes, but not limited to, routine laboratory procedures, diagnostic procedures, body checks, evaluations done by nurses, social workers, psychologists, activity therapist and medical treatment rendered by my physician(s).
2. I understand that if the inpatient treatment team determines that I have a substance abuse/dependence problem requiring treatment, I may be required to remain on the unit for all treatment. Visitation may be restricted for a period of time. Any restrictions will be reviewed daily by the inpatient treatment team. The purpose for these requirements is for medical stabilization and prevention of further access to substances that may be abused.
3. I understand I can ask to leave at any time after I am admitted; however, if I should choose to leave inpatient treatment Against Medical Advice (AMA), it is my intention to give the staff a written notice 48 hours prior to the time I actually leave the hospital. If it is determined by my physician that I do not pose a danger to myself or others but my physician determines that I need to stay to complete my treatment, and I disagree with that opinion, I will be discharged Against Medical Advice. If I am discharged AMA, I understand that I will not be provided with prescriptions **or** any outpatient follow-up treatment.
4. **I understand that if my physician determines that my discharge might pose a danger to myself or others, I may be detained for up to three (3) business days during which my physician will initiate an involuntary commitment procedure for acute care.
5. I understand that should my conduct become disruptive or dangerous to myself or to others, the physician may order treatment with medication, seclusion, or restraint as needed.
6. I understand that I have the fundamental right to control decisions relating to the rendering of health care including the decision to have all life-sustaining procedures withheld or withdrawn in instances of terminal condition, and explaining these rights.

INPATIENT AND OUTPATIENT TREATMENT:

1. I consent to participate in the development and implementation of the treatment plan, and I understand that such treatment includes, but is not limited to: individual, group, marital, and family conferences, recreational activities and outings, and medical treatment which may be deemed necessary or advisable during my course of treatment.
2. I have been informed of my condition, problems related to recovery and likelihood of success.
3. I have been informed of proposed interventions, treatments and medications and the potential benefits, risks and side effects to each.
4. I have been informed of alternative interventions, treatments, medications and my right to refuse such to the extent permitted by law.
5. I recognize that Parkside, Inc. is a teaching facility and consent to the presence of student observers and treatment by supervised resident physicians.
6. I understand that my medical records may be reviewed by outside auditors such as Medicare/Medicaid, private insurance companies, the Joint Commission for Accreditation of Healthcare organizations and the Oklahoma State Dept. of Health.
7. I understand and authorize the review and/or release of information of my medical records to contacting agencies for services rendered and continued treatment as outlined in the Notice of Privacy Practices.
8. ** I have been provided with information regarding the transmission of the AIDS virus, behaviors that can place other and me at risk and information on how to obtain HIV testing, if needed.

9. ** I understand that in entering treatment, I must conduct myself in such a way as to protect myself from exposure to or transmission of Infectious diseases such as AIDS, hepatitis, venereal disease, and any other communicable disease.
10. ** I acknowledge that I have received information about tuberculosis including: Symptoms of TB, how TB is spread, and the risk factors for TB and how to obtain a test for TB. I have been given an opportunity to have my questions answered.

** I have received copies of the following: Patient and Client Rights, Patient and Client Responsibilities, Medicare Patient and Client Appeal Process, Grievance process and client handbook (which explains hospital rules). As part of my treatment, there may be trips made outside of the hospital and volunteers may be used on occasion.

CERTIFICATION:
I hereby certify that I have read the contents of this form and have had the opportunity to ask any questions and obtain explanations to my satisfaction. I certify that I understand its content and significance. I further certify that all information requested during my evaluation is correct to the best of my knowledge. False information or information withheld could result in transfer or discharge.

If voluntarily admitted inpatient or outpatient, I understand that I am voluntarily consenting to treatment by Parkside, Inc. clinical staff.

Signature of Patient/Client	Date	Signature of Staff	Date

Signature of guardian or legal representative	Date

Note: If patient has a guardian or representative, that person must sign.

If patient is unable to consent and has no guardian/legal representative, complete below:
Patient is unable to give consent because: _____

_____

If the patient is unable to comprehend his/her rights, a copy of the Mental Health Patients' Bill of Rights and Responsibilities and information regarding Advance Directive will be given or mailed to the person listed below within 24 hours of admission. Print name and address:

Name: _____

Address: _____ _____

Parkside
Psychiatric Hospital & Clinic

PARKSIDE, INC.
Health Screening

Patient Name: _____ Patient Number: _____

SSN: _____ Date of Birth: _____ Date of Completion: _____

Person Completing Form: _____ Relationship: _____

PRIMARY CARE DOCTOR

Name: _____

Address: _____

Phone: _____

Date of Last Visit: _____ Reason for visit: _____ Date of Last Physical Exam: _____

DO YOU NOW HAVE or HAVE YOU EVER HAD… (If yes, explain)

YES NO PAST Eye problems or need glasses? _____

YES NO PAST Hearing problems? _____

YES NO PAST Speech problems? _____

YES NO PAST Dental problems? _____

YES NO PAST Fainting spells, passing out, or dizzy spells? _____

YES NO PAST Seizures, Epilepsy, convulsive fits? _____

YES NO PAST Inability to move a part of your body? _____

YES NO PAST Bad headaches? _____

YES NO PAST Goiter or thyroid problems? _____

YES NO PAST Pains in your chest? _____

YES NO PAST High blood pressure? _____

YES NO PAST Swelling in hands, feet, or ankles? _____

YES NO PAST Kidney troubles? _____

YES NO PAST Stomach troubles or ulcers? _____

YES NO PAST Diabetes? _____

YES NO PAST Liver disease, or skin or eyes turn yellow? _____

YES NO PAST HIV – AIDS ? _____

YES NO PAST Recent change in appetite or eating habits? _____

YES NO PAST Recent change in bowel habits? _____

YES NO PAST Medical reasons you can not work? Explain: _____

YES NO PAST Other medical problems? Explain: _____

YES NO PAST Have you or any of your family members been exposed to tuberculosis (TB)? _____

YES NO PAST Have you ever had a positive tuberculosis (TB) skin test? If yes, name of medication taken: _____

How long did you take the medication? _____ Date & Location of last chest x-ray: _____

YES NO PAST Have you ever had surgery or other medical procedures? Explain: _____

YES NO Are you currently experiencing pain? If yes, how bad does it feel: (none0 1 2 3 4 5 6 7 8 9 10Extreme)

Describe type of pain and location: _____

Females Only → Are you currently pregnant? ☐ Yes ☐ No Any past trouble with pregnancy? ☐ Yes ☐ No _____

FAMILY MEDICAL HISTORY

Has any member of your biological family ever had any of the following conditions? If yes, explain.

Heart problems? ☐ Yes ☐ No _____ Diabetes? ☐ Yes ☐ No _____

High blood pressure? ☐ Yes ☐ No _____ Cancer? ☐ Yes ☐ No _____

HABITS (average amounts)

Sleep	_____	Hours/night	Cigarettes	_____	Packs/day	Alcohol	_____	Amount/day
Water	_____	Glasses/day	Cigars	_____	Per/day	Marijuana	_____	Amount/day
Coffee	_____	Cups/day (regular or decaf)	Other tobacco:			Other drugs:		
Tea	_____	Glasses/day (regular or decaf)	_____	_____	Per/day	_____	_____	Amount/day
Soda	_____	Glasses/day (regular or diet)	_____	_____	Per/day	_____	_____	Amount/day

MEDICATION HISTORY (all medications, including over-the-counter)

***By mouth, Injection, IV, other means**

Present/Past	Medication	Strength	*Route Taken	How Often Taken	Start Date	End Date	Reason Taken	Prescribing Doctor
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No

If yes, please explain: _____

_____

STOP

DO NOT WRITE BELOW THIS LINE

PHYSICIAN RECOMMENDATION

It is the recommendation of the Parkside Medical Staff that each individual make regular visits to a physician for screenings and physicals. Upon review of the information provided by the client and as documented on this form:

_____ It is recommended that the individual named on this form receive a medical history and physical or other medical treatment prior to commencement / continuation of treatment for psychiatric disorders.
(circle one)

_____ It is **not required** that the individual named on this form receive a medical history and physical or other medical treatment prior to the commencement and/or continuation of treatment for psychiatric disorders.

_____ _____

Physician Signature Date

Parkside Psychiatric Hospital & Clinic

Authorization for Use and Disclosure of Protected Health Information

For exchange of information between Parkside and ONE facility or person

Patient Label

Patient Name:	Record #:
Address:	Birth Date:
Phone no:	Social Security No:

Name: **Parkside Hospital**	Name:	***Check as many as apply***	
Attn: **Medical Records**	Address:	Send to ☐	Mail ☐
Address: **1620 East 12th St.**		Receive from ☐	Fax ☐
Tulsa, OK. 74120	Phone: Fax:		Verbal ☐

MINIMUM NECESSARY INFORMATION TO BE RELEASED/SHARED for services from: _____ to _____

☐ Discharge Summary ☐ Psych Evaluation ☐ Treatment Plan(s) ☐ Psychosocial exam ☐ Progress Notes ☐ Medication sheets ☐ Other specify):__ _____

PURPOSE (CHECK): ☐ Treatment/consult ☐ Patient use ☐ Verify treatment ☐ other: _____

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE:

Information in your medical record that you have or may have a communicable or noncommunicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court, by the Department of Health or by law.

I UNDERSTAND THAT:

- If my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I agree to its release: _____ ***initials***
- I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that if my records contain alcohol and /or drug treatment information and I am legally considered a minor, I am the responsible individual that must authorize this disclosure (per 63 Okla.Stat. 2602).
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in 6 months or as follows: _____.
- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- I have been provided a copy of this form.
- I may inspect or copy the protected health information to be used or disclosed.
- **Payment for records is required in advance of receipt of records**.

I authorize the above-named entity to use and disclose the confidential and protected health information specified above:

Signature: _____ Date/time: _____ _____:_____

Signature of person signing form if not patient: _____ Authority: _____

Identity verified via: ☐ photo ID ☐ matching signature ☐ other: _____ Staff signature: _____

Approval for release of information ☐ Yes ☐ No _____Therapist Signature Date/Time _____

Approval for release of information ☐ Yes ☐ No _____Physician Signature Date/Time _____

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.

Organized Health Care Arrangement

Parkside, its medical staff and other health providers are part of a clinically integrated care setting that creates an organized health care arrangement under HIPAA. This allows sharing of information among legally separate entities to enhance the delivery of quality care to our patients; however no entity is responsible for the medical judgment or patient care provided by the other entities in the arrangement. These entities may have different privacy practices for medical information they create or keep in their offices.

A copy of this may be found in the Administrative Offices of each Parkside facility. If you have any questions about this notice, please contact the Privacy Officer at 918-588-8884.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Definitions:

- Protected Health Information or PHI: your personal and protected health information that we use to render care to you and bill for services provided.
- Privacy Officer: the individual in the hospital who has responsibility for developing and implementing all policies and procedures concerning your PHI and receiving and investigating any complaints you may have about the use and disclosure of your PHI.
- Business Associate: an individual or business that is independent of Parkside that work for Parkside to help provide Parkside or you with services.
- Authorization: we will obtain an authorization form you giving us permission to use or disclose your protected health information for purposes other than for your treatment, to obtain payment of your bills and for health care operations of Parkside or under the Organized Health Care Arrangement.
- Organized Health Care Arrangement: this hospital and the independent health care professionals who have been granted privileges to practice at the hospital are part of a clinically integrated care setting in which your PHI will be shared for purposes of treatment, payment, and health care operations as described below.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We are required by law to protect your privacy and the confidentiality of your personal and protected health information and records. We will give you notice of our legal duties and privacy practices with respect to medical information about you. We will follow the terms of the notice currently in effect.

The entities covered by this Notice include:

- This hospital and all professionals authorized to enter information into your record.
- All departments and units of Parkside
- All employees, staff and other Parkside personnel.
- Physicians, psychologists and therapists who are independent contractors of Parkside

Parkside creates a record of the care and services you receive in our facilities. Your medical records and billing information are created and retained either in paper or computerized formats. That information is accessible to hospital personnel and members of the medical staff. Proper safeguards are in place to discourage improper use or access. All these entities, sites, and locations follow the terms of this notice and may access and share medical information with each other for treatment, payment or the health care operation purposes described in this notice.

Parkside Psychiatric Hospital & Clinic

NOTICE OF PRIVACY PRACTICES

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe ways that we use and disclose medical information in the normal course of business. All the ways we are permitted to use and disclose information will fall within one of these categories.

Routine Uses

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, clinicians or other Parkside personnel who are involved in taking care of you, including students of a professional training program that Parkside may sponsor.
- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at Parkside may be billed and payment may be collected from you, an insurance company or a third party. We may disclose medical information to your health plan, insurance company, HMO, or their utilization review contractor in order to obtain prior approval or to determine whether your plan will cover a particular treatment.
- **For Healthcare Operations**. We may use and disclose medical information about you for healthcare operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine information about you and other Parkside patients in order to plan for other services and/or treatments we should offer, what services are not needed, and whether certain treatments are effective. We may also disclose information to doctors, nurses, clinicians and other Parkside personnel for review and learning purposes.

  We may also combine the medical information we have with medical information from other healthcare organizations to evaluate how we are doing when compared to others in the state or country. In these cases, unless required by law (see below), we will remove information that identifies you from this set of information so others may use it to study health care without learning the identity of specific patients.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for services at Parkside
- **Treatment Alternatives**. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **As Required by Law**. We will disclose medical information about you when required to do so by federal, state or local law. For example, Oklahoma law requires us to report all deaths that occur in the hospital to the Oklahoma Department of Health.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special Situations

- **Worker's Compensation**. We may release medical information about you to your employer or his/her designee for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks**. We may disclose medical information about you for public health activities. These generally include the following:
  1. To prevent or control disease, injury or disability;
  2. To report deaths;
  3. To report reactions to medications or problems with products;

4. To notify people of recalls of products they may be using;
5. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
6. To notify the appropriate government authority if we believe a patient has been the victim of abuse or neglect.

- **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. Examples may include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Accrediting Organizations**. We may disclose medical information to an organization that Parkside has contracted with for purposes of accreditation such as The Joint Commission and the Oklahoma Health Care Authority, etc.
- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court order.
- **Law Enforcement**. We may release medical information if asked to do so:
  1. In response to a court order, warrant, summons or similar process;
  2. To identify or locate a suspect, fugitive, material witness, or missing person.
  3. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  4. About a death we believe may be the result of criminal conduct;
  5. About criminal conduct at the facility; and
  6. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors**. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
- **Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or when they conduct special investigations.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to request to inspect and copy medical information that may be used to make decisions about your care. The Clinical Director may deny your request to some or all of your record if it poses a risk to your safety or to the safety of others.
  To request an inspection, your request must be made in writing to Parkside. If you request a copy of the information, we will charge a fee for the cost of copying, mailing or other supplies associated with your request. The fee would be at the Oklahoma statutory rate (currently $1.00 for the first page and .50¢ each additional page) per copied page plus postage. If the Clinical Director or Practitioner denies your request, you will receive a written explanation for the denial.
- **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Parkside
  To request an amendment, your request must be made in writing and submitted to the Clinical Director for Parkside. You must also provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us or the person or entity that created the information is no longer available to make the amendment;
2. Is not part of the medical information kept by Parkside;
3. Is not part of the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an "Accounting of Disclosures." ***To request an accounting of disclosures***, you must submit your request in writing to Parkside. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. Any additional requests in that 12-month period will require payment. We will notify you of the costs and you may choose to withdraw or modify your request before costs are incurred.

- **Right to Opt out of Receiving Fundraising Communication:** We may use medical information about you to contact you in the future to raise money for any fundraising campaign. You may notify the Privacy Officer to opt out of receiving further fundraising communications.

- **Right to Request Restrictions**. You have the right to request a restriction of limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or a friend. WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. ***To request restrictions***, you must make your request in writing. In your request you must tell us: 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply (i.e. disclosures to your spouse).
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. ***To request a confidential communication***, you must make your request in writing to Parkside. We will not ask you the reason for your request. We will accommodate all reasonable requests. Our request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of this Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may obtain a copy of this notice at our web site, **www.Parksideinc.org**. ***To obtain a paper copy of this notice***, contact the Privacy Officer at 918-588-8884.

- **Right to be Notified of a Breach of your Protected Health Information** at Parkside. We are committed to protecting patient information; in the event that patient information is disclosed negligently, pending an investigation, you will be notified immediately of the matter.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the administrative office of all facilities. The notice will contain, on the first page, the effective date. In addition, each time you are admitted to Parkside for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a **written** complaint with the **Parkside Grievance Coordinator/Grievance Officer** at **Parkside Hospital, 1620 E. 12th Street, Tulsa, OK. 74120.**

Parkside Grievance Coordinator – Tyler Doane - (918) 586-4233
tdoane@parksideinc.org

Other agencies that accept grievances relating to quality of care or safety (such as abuse, neglect, or harm to a patient) are the following:

The Joint Commission – 1-800-994-6640 or 1-630-792-5636
Office of Quality Monitoring
The Joint Commission
One Renaissance Blvd.
Oak Brook Terrace, IL. 30181

The Oklahoma State Department of Health – David Shenold, 405-271-6576
Medical Facilities
Protective Health Services
1000 NE 10th Street
Oklahoma City, OK 73117

Centers for Medicaid and Medicare Services (CMS) – Dallas Regional Office
Gerardo Ortiz – 214-767-6300 or RODALD@cms.jjs.gov

Oklahoma Department of Human Services – OKDHS – 1-405-521-3646
P.O. Box 25352
Oklahoma City, OK 73125

Child Abuse Hotline – 1-800-522-3511 or 1-800-422-4453

Office of Client Advocacy (OCA) 1-405-5255-4850
P.O. Box 25352
Oklahoma City, OK 73125

Adult Protective Services – 8a – 5p (918) 430-2300; after hours – 1-800-522-3511

The Oklahoma Quality Initiative Organization: 405-840-3511
Oklahoma Foundation of Medical Quality (OFMQ)
14000 Quail Springs Parkway # 400
Oklahoma City, OK 73134

Oklahoma Commission on Children and Youth
1111 N. Lee Ave., Suite 500
Oklahoma City, OK 73103
1-866-335-9288

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of your medical information NOT covered by this notice or applicable laws will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you. Disclosures made with your consent will not appear on the "accounting of disclosures" log.

Parkside Psychiatric Hospital & Clinic

NOTICE OF PRIVACY PRACTICES

PATIENT LABEL

Patient Name_____ Patient ID _____

JOINT NOTICE OF PRIVACY PRACTICES

RECEIPT ACKNOWLEDGEMENT

A complete description of how your medical information will be used and disclosed by this facility is in our NOTICE OF PRIVACY PRACTICES.

I have received a copy of Parkside's Joint Notice of Privacy Practices.

Patient Signature_____ Date _____

Parent / Legal Guardian Signature_____ Date _____

Witness Signature_____ Date _____

NOTICE OF PRIVACY PRACTICES

PATIENT LABEL

Patient Name_____ Patient ID _____

NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this facility is in our NOTICE OF PRIVACY PRACTICES.

PATIENT RIGHTS AND RESPONSIBLITIES

A description of your rights and responsibilities as a patient at Parkside are provided at admission**.**

MEDICAL TREATMENT RIGHTS UNDER OKLAHOMA LAW

A description of your rights as required by section 3080.5(B) of Title 63 of Oklahoma Statutes.

RECEIPT ACKNOWLEDGEMENT

I have received a copy of Parkside's Notice of Privacy Practices, and Patients' Rights and Responsibilities.

Patient Signature_____ Date _____

Parent / Legal Guardian Signature_____ Date _____

Witness Signature_____ Date _____

QUESTIONS AND ANSWERS ABOUT THE OKLAHOMA ADVANCE DIRECTIVES FOR HEALTH CARE

Q. What is the purpose for Advance Directives?

A.

1. To recognize your right to control some aspects of your own medical care and treatment, including but not limited to the right to decline medical treatment or to direct that it be withdrawn, even if death ensues;
2. To recognize that your right to control some aspects of your own medical treatment is protected by the Constitution of the United States and overrides any obligation the physician and other health care providers may have to render care or to preserve life and health;
3. To recognize that decisions concerning your medical treatment involve highly sensitive, personal issues that do not belong in court, even if you are unable to act on your own behalf, so long as a proxy decision-maker can make the necessary decisions based on your know intentions, personal views, or best interests. If evidence of your wishes is sufficient, those wishes should control; if there is not sufficient evidence of your wishes, the proxy's decisions should be based on his/her reasonable judgment about your values and what your wishes would be based upon those values.

Q. Who may sign an Advance Directive?

A. Any person 18 years of age or older who voluntarily does so, provided that person is in sound mind as evidenced by two witnesses.

Q. Does the Advance Directive require my signature more than one time?

A. Your signature may be required many times depending on your wishes.

Q. Can just anyone sign as a witness?

A. No. Each witness **SHALL NOT BE**: 1. A person who will inherit from you;
2. Under age of 18 years.

Q. What is meant by a terminal condition?

A. An incurable and irreversible condition that, even with the administration of life-sustaining treatment, will, in the opinion of the attending physician and another physician, result in death with six months.

Q. Suppose I change my mind?

A. You may revoke part or all of your Advance Directive at any time and in any manner regardless of your mental or physical condition. Your act becomes effective as soon as you tell your attending physician or other health care provider. Your request to revoke part or all of your Advance Directive must be made a part of your medical record by the attending physician or other health care provider.

Q. What if my physician does not want to comply?

A. The physician shall promptly, as practical, take all reasonable steps to arrange care by another physician or health care provider when you become a qualified patient.

Q. What is a qualified patient?

A. A patient 18 years of age or older who has executed and Advance Directive and who has been determined to be in a terminal condition by the attending physician and another physician who has also examined the patient.

Q. How am I protected from a misjudgment by a physician?

A. The law requires a separate opinion by a second physician who agrees that your condition is terminal. This second opinion must be made a part of your medical record.

Q. What if I have already signed a Directive?

A. Your Directive will be enforceable according to its terms under the law. However, you may want to consider singing a new Advance Directive to prevent any misunderstanding from developing, or to take advantage of additional options under the law. If you have more than one valid Advance Directive, the last one you signed shall be considered to be your last wishes.

Q. What should be done with the Directive after it has been signed and witnesses?

A. First, photocopies should be made for your personal records, your family members and your proxy and alternate if you have chosen them. The original or photocopy should be furnished to your physician or other health care provider who shall make it a part of your medical record. If your physician other health care provider is unwilling to comply with the Advance Directive, (s) he is required to tell you this promptly.

Q. What should I do if I wish to complete an Advance Directive while at Parkside, Inc.?

A. Discuss this with your treatment team. They will contact the social worker who will assist you with a referral to legal services.

PARKSIDE, INC.
NOTICE REGARDING
ADVANCE DIRECTIVE FOR HEALTH CARE

Patient Name: _____ MR #: _____

Date of Admission: _____ Social Security #: _____ DOB: _____

I have been informed of my right to formulate an Advance Directive. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this hospital.

I have previously executed an Advance Directive and will make a copy available to Parkside, Inc.

I have not executed an Advance Directive and do not wish to do so at this time. If I later decide to execute an Advance Directive, I will notify the treatment team of my decision.

I wish to execute an Advance Directive. (Complete below)

_____ _____

Staff Signature Date Patient Signature Date

For hospital use only:

If patient wishes to execute an Advance Directive the following measures were taken:

_____

_____

_____

_____

Staff Signature & Date