CLIENT RIGHTS AND RESPONSIBILITIES

Client:_____ DOB:_____ SS#: _____

Welcome to Turning Point System of Care! You are entitled to certain rights during your treatment. These rights are guaranteed by your provider, by TPSOC and, in certain respects, by state and federal law statute.

Your rights include:

1. Access to equal treatment without regard to gender, sexual orientation, race, religion, age or handicap, including the right to practice your religion.
2. Treatment that is free from abuse, financial or other exploitation, retaliation, humiliation and neglect.
3. A full and clear explanation of services available. Your right to make informed consent, refusal, or expression of choice about: service delivery, release of information, concurrent services, composition of the service delivery team, and involvement in research projects, if applicable.
4. Protection of your privacy and confidentiality under state and federal guidelines. In most cases this means that records cannot be released unless you specifically authorize that release. Please be aware that information about possible child abuse, including physical and sexual abuse, neglect and/or threats to the direct safety of your child must be reported to the responsible state agency. Also, if it is learned that you or your child intends to harm themselves or someone else, your treatment providers are required to take steps to attempt to prevent such harm. Your information will not be used for any type of marketing purposes.
5. A clear and complete description of the treatment proposed, as well as your responsibilities in carrying out that treatment.
6. If a parent or guardian, access to your or your child's record, unless portions of the record are determined by a court or medical staff to be detrimental to you or your child's safety. Access to information pertinent to care will be provided in sufficient time for you to make decisions regarding your treatment.
7. Cooperation in obtaining an independent second opinion and/or legal counsel at your own expense at any point in the treatment process.
8. To know the credentials of your provider(s) and the scope of services they can deliver.
9. Access to a clear description of the process through which you may express any concerns or complaints about your care. To be able to express concerns and grievances without reprisals and a process to appeal the decision of the grievances. The right to investigation and resolution of any alleged infringement of rights.
10. To send and receive mail, telephone calls and receive visitors unless counter-indicated by your treatment and when these occur be fully explained.
11. To have access or referral to legal entities for appropriate representation, self-help and advocacy support services, and for your provider to adhere to research guidelines and ethics if you would choose to participate in any form of research and/or experimental procedures.
12. To access DMHA, call 800-901-1133, for TDD, call 317-232-7844 or for Indiana Disability Rights call 800-622-4845, 317-722-5563 (Local TTY) or 800—838-1131 (Toll Free TTY) or visit www.indianadisabilityrights.org.

In signing this, I indicate that I understand and accept the rights and responsibilities outlined above. I have had an opportunity to ask questions and discuss this information.

_____	_____	_____
Signature/Custodial Parent/Legal Guardian	Date	Relationship
_____	_____	_____
Witness	Date	Relationship

TURNING POINT SOC TREATMENT ACKNOWLEDGEMENTS / CONSENTS

Please indicate your consent to each term by initialing next to each line:

____I agree to be evaluated by a member of the Turning Point treatment team. Following the evaluation, I will be asked to consent to specific treatment recommendations as stated in the treatment plan.

____I understand therapy & coaching sessions are private and conversations during sessions cannot be recorded without consent from both the patient and provider.

____I understand that for my safety, my medication fill history may be obtained electronically from the pharmacy database to ensure thorough medication reporting.

____I understand student/intern nurses and therapists may be involved in my treatment and I can refuse treatment that is provided by them at any time.

____I have been offered a copy of my Turning Point SOC Rights and Responsibilities regarding services being provided. A copy of these Rights and Responsibilities will be posted in the office in which I will be receiving recovery support, or I may review them on Turning Point's website: www.turningpointsoc.org.

____ I give Turning Point permission to communicate with me via text. I am aware that texting is not secure, and that the confidentiality of the texts I send cannot be guaranteed.

____ I consent to participate in telehealth with Turning Point SOC as part of my services. I understand that there are risks associated with telehealth, including but not limited to, disruption of communication by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. To learn more about telehealth services, I can visit at anytime Turning Point's website: www.turningpointsoc.org.

____ I understand all these services are voluntary and that I may revoke consent from any or all of them at any time.

____I have received a summary of Turning Point's Notice of Privacy Practices and understand that these privacy practices apply to all services I receive from Turning Point. I am aware that detailed information is available upon request and is available on Turning Point's website: www.turningpointsoc.org

____I understand that my confidentiality is protected by Turning Point's Privacy Practices unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

By signing below, I acknowledge that the corresponding statements and information have been explained and reviewed with me, and I understand them. I voluntarily consent to participate in treatment.

_____		_____	
Client Signature	Date	Client Printed Name	
_____		_____	
Client Representative Signature (if applicable)	Date	Representative's Relationship to Patient	

For Staff Use Only: ☐ Client refused to sign per _____ *(Staff Initials)* ☐ Client unable to sign per _____ *(Staff Initials)*

FINANCIAL ASSISTANCE

Self Pay Sliding Fee Scale	HHI Minimum	HHI Maximum	Fee Per Service
1	$0	$10,000	$1
2	$10,001	$20,000	$2
3	$20,001	$30,000	$3
4	$30,001	$40,000	$4
5	$40,001	$50,000	$5
6	$50,001	$75,000	$10
7	$75,001	$99,999	$25
8	$100,000	$150,000	$75
9	$150,001	$200,000	$135

Size of family unit: _____ (Number of individuals supported by the family income)

Total annual gross household income: _____

Financial (Payment, Charges & Billing)

_____I and/or the individual seeking treatment will be financially responsible to pay Turning Point for any costs incurred to collect this debt, including but not limited to collection fees, interest fees, and attorney fees. I understand that some services may be court mandated. I understand also that some services may include preparation of reports, testimony, and other non-direct patient services.

____I understand these services will be charged at the rate discussed with me.

____I agree to notify Turning Point of changes that may affect my fees.

____I understand that I am responsible for any remaining balance after insurance has paid or if insurance does not pay (i.e., copays/deductables).

____I agree to Turning Point Systems of Care collecting any amounts I may owe; you may contact me by telephone at any telephone number associated with my account. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of adialing service, as applicable.

____**I understand that payment is due at the time of service, and that all co-pays are due at each visit.** Any other arrangements must be approved in advance.

This is to advise you that unless otherwise requested, the Turning Point will file all services with your insurance company and/or Medicaid/Medicare. If you request, we not bill your insurance company, you will be responsible for your entire balance or can request scholarship if available.

Check one:

☐ My signature certifies that the total gross household income is accurate. _____
Client/Caregiver Signature Date

☐ My signature certifies I have no income. _____
Client/Caregiver Signature Date

For Staff Use Only:

Is the client's income less than 200 % of poverty considering the size of the family unit? ◯ YES ◯ NO

Client Services (Complaints and Compliments) - Who to contact if you have a concern about Turning Point Services 1/1/2023			
	Who to contact	**Phone and Fax**	**Email**
Client Care	Any staff member		
	Division of Mental Health & Addictions (DMHA)	800 901-1133	
	Indiana Disability Rights	317-722-5555 800-622-4845	info@IndianaDisabilityRights.org
	Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	800 994-6610	complaint@jcaho.org
	Medicare Beneficiary Helpline	800-288-1499	
	Indiana State Board of Health	800-246-8909	
	Indiana Mental Health & Addiction Ombudsman	800-555-6424	
Safety	Safety Director	(765) 438-9597	
Privacy	Privacy Officer	(765) 860-8365 Ext: 1001	
	Office For Civil Rights (HHS)	312 886-2359 (Region V) 800 368-1019 (Help desk) 312 886-1807 (Fax)	OCRComplaint@hhs.gov
Billing	Director of Billing and Reimbursement	(765) 860-8365 Ext: 1001	
Corporate Compliance	Corporate Compliance Officer	(765) 513-5745	
All other concerns	Consumer Advocate	(765) 513-5745	