BENCHMARK INTEGRATED HEALTH

3829 Woodley Rd, Suite B6, Toledo, OH 43606

Office: 419-690-4544
Web: www.benchmarkih.com

CLIENT REFERRAL FORM

CLIENT INFORMATION	
Name:	**Race:** **Ethnicity:** **Gender:**
DOB: **Age:** **Sex:**	**Email Address: Guardians**
Marital Status:	**Guardian (if minor):**
SSN:	**Insurance Name:**
School (if Applicable)	**Member ID:** **Medicaid (MMIS)**
Insurance Verified: ☐ **No or** ☐ **Yes**	**Reference Number:**
Insurance Verified by:	
REFERRAL INFORMATION	
Address (city, state, zip):	
Phone Number(s):	
Reason for Referral:	
Referred By: **Contact Number:** **Referral Date:**	
Notes:	
SERVICE LOCATION	
☐ **Cleveland, OH**	☐ **Toledo, OH**
BIH STAFF USE ONLY	
Date of Scheduled Evaluation:	**Diagnostic Evaluation with:**
Location of Evaluation: ☐ **Office** ☐ **Home**	

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BEHAVIORAL HEALTHCARE INC.

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CONSENT FOR TREATMENT

Client Name: _____

Date of Birth: _____ **Last Four of SSN:** _____

I/We hereby give consent for mental health treatment (which may include services, supports) for the above-named Consumer. Services may include one or more of the following:

1. **Diagnostic Evaluation and Diagnostic Evaluation Update**
2. **Community Psychiatric Service Treatment (CPST)**
3. **Psychotherapy (Individual, Family, Group, Crisis)**
4. **Psychoeducation Support Services (Therapeutic Behavioral Services, Psychosocial Rehabilitation)**
5. **Assertive Community Treatment (ACT)**
6. **Intensive Home-Based Therapy (IHBT)**
7. **Substance Use Disorder Assessment and ASAM**
8. **Substance Use Disorder Services (Case Management; Psychotherapy; Individual Counseling; Group)**
9. **Intensive Outpatient Treatment**
10. **Laboratory Analysis**
11. **Medication Management**

I understand that all information shared with service providers at **Benchmark Integrated Health** is confidential and no information will be released without my consent. During the course of treatment at **Benchmark Integrated Health**, it may be necessary for my service provider to communicate with providers at **Benchmark Integrated Health**. While written authorization will not be requested, prior to any discussion with **Benchmark Integrated Health** providers, I understand that only provider will discuss all communications with me. In all other circumstances, consent to release information is given through written authorization. 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 which include the following:

A. When there is risk of imminent danger to myself or to another person, the service provider 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 provider is legally required to take steps to protect the child and to inform the proper authorities.
C. When a valid court order is issued for medical records, the provider and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at **Benchmark Integrated Health**, I may discuss them with my provider or the Clinical Supervisor. I have read and understand the above. I consent to receive the treatment offered to me by **Benchmark Integrated Health**. I understand that I may stop treatment at any time.

The consent/or treatment process has been thoroughly explained to me and I understand that I may stop treatment at any time.

_____ _____
Consumer Signature **Date**

_____ _____
Parent/Legal Guardian Signature **Date**

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RIGHT TO REFUSE TREATMENT

You have the right to refuse treatment. If you refuse treatment, **Benchmark Integrated Health** staff will, with your approval, offer assistance in developing alternative approaches to ensure you and or/your minor child(ren) receive the needed/ recommended services. If you refuse treatment sign below.

Right to Withdraw from Treatment

You have the right to withdraw consent for treatment at any time. If you choose to withdraw consent, **Benchmark Integrated Health** staff will explain any implications or potential consequence for withdrawing treatment. If you have chosen to withdraw consent for treatment, please sign and date below.

Name: _____ **Date:** _____

Guardian Name: _____ **Date:** _____

Witness: _____ **Date:** _____

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CONSENT TO TELE-MENTAL HEALTH

Client Name: _____

Date of Birth: _____ **Last Four of SSN:** _____

Purpose and Nature of Telehealth Treatment:
I hereby provide my consent to participate in telehealth treatment with **Benchmark Integrated Health** for the diagnosis and treatment of behavioral health conditions, addiction, and related concerns. Telehealth involves the use of electronic communications to interact with clinical personnel remotely. This may include audio, video, and/or other electronic means to conduct consultations, therapy, counseling, follow-up, education, and related services.

Risks, Benefits, and Alternatives:
I understand that telehealth provides the benefit of convenient access to healthcare, counseling, and support without the need to physically visit the clinic. However, I acknowledge that the inability to have direct, physical contact with clinical providers is a distinction between telehealth and in-person care. There is a risk that technical limitations may affect the completeness of information exchange during telehealth sessions. I am aware that telehealth is not intended to replace emergency medical care, and I agree to contact 911 or visit the nearest emergency department in case of a medical emergency.

Information Privacy and Records:
I am aware that the privacy laws and regulations that apply to in-person care also apply to telehealth. I understand that the information shared with clinical providers during telehealth sessions will be treated with confidentiality and in compliance with relevant legal requirements and Facility policies.

Rights and Withdrawal of Consent:
I retain the right to withhold or withdraw my consent for telehealth treatment at any point before or during a session. I acknowledge that withdrawing consent will not impact my right to future care or treatment or affect my eligibility for program benefits.

Confirmation of Understanding and Consent:
I have read, understood, and had the opportunity to ask questions regarding the information presented above. My inquiries related to telehealth and the details outlined above have been addressed to my satisfaction. By signing below, I voluntarily provide my consent to receive and participate in telehealth treatment with **Benchmark Integrated Health**.

I acknowledge that there additional 24/7 phone numbers for emotional support:

- **National Suicide Prevention Lifeline: 1-800-273-TALK (8255)**
- **Crisis Text Line: Text 741-741**
- **National Domestic Violence Hotline: 1-800-799-SAFE (7233)**
- **Emergency: 911 (Police and Fire Department)**

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Client Consent to the Use of Tele-Mental health

I have read and understand the information provided above regarding tele-mental health, have discussed it with my mental health professional as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of tele-therapy in my medical care. I hereby authorize **Benchmark Integrated Health** to use tele-mental health in the course of my mental health diagnosis and treatment.

Client Signature: _____ _____

Date

Parent/ Legal Guardian Signature: _____ _____

Date

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Client Rules and Expectation

Rules and Expectation

1. No chemical use, of any kind, including tobacco products on the premises.
2. No stereo, radios, CD players, etc. on while the group is in session
3. No cellular telephones will be permitted to be on while the group is in session.
4. Minor clients may not leave without permission while in session.
5. Clients will be expected to use respectful language and refrain from the use of profanity.
6. No verbal or physical assault to anyone while on Benchmark Integrated Health grounds or any other place where the group is being held. Non-compliance will result in immediate suspension from the group and may result in termination from the agency. Benchmark Integrated Health staff does not use seclusion or physical restraint; however, should the need arise, staff will contact local police to de-escalate a dangerous situation.
7. No gang signs, gang talk, or gang writings of any kind will be permitted.
8. Possession of weapons or sharp objects is not permitted on Benchmark Integrated Health, or off grounds while participating in a Benchmark Integrated Health function.
9. No food or beverage unless prior approval is granted from the group facilitators.
10. If you are prescribed prescription medications for a diagnosed medical condition and there is a medical need for you to carry the medication with you while receiving treatment and/or participating Benchmark Integrated Health activities, you are expected to maintain control of the medication at all times and to maintain personal responsibility for ensuring it is not used by or distributed to any other person to whom it was not prescribed.

CLOTHING

1. Clients are not allowed to wear clothing that refers to alcohol, drugs, or tobacco products.
2. No gang-related clothing at any time.
3. A shirt and shoes are required at all times, no halter tops or tank tops.

PEERS RELATIONSHIPS

1. No sexual or romantic relationships between group members.
2. No physical contact between members.

CONFIDENTIALITY

1. Clients must abide by rules of confidentiality including not repeating any information discussed in the group or revealing any group member's identity with anyone outside of the group.

REQUIREMENTS FOR COMPLETION OF SUBSTANCE ABUSE TREATMENT

1. All programs are abstinence-based and require abstinence from alcohol, and drugs while attending treatment. Random urine samples will be taken throughout treatment. Failure to comply could result in discharge.
2. Regular attendance at the group is expected. Be on time, chronic lateness is grounds for discharge from treatment. The client (or guardian) must call on the day of treatment for clients to be excused.
3. Clients will be expected to participate in group activities and complete assignments as given by group facilitators.
4. Family participation is required for minor clients. Group facilitators will notify the parent/guardian of the meeting time.

5. Support group attendance is required. Signed slips from the designated meeting will be collected as verification of attendance. Failure to attend could lead to discharge.
6. Prior to successful discharge from treatment clients will complete a continuing care/relapse prevention plan.
7. Benchmark Behavioral Health is not responsible for lost, stolen, or damaged belongings.
8. Any damage done to Benchmark Behavioral Health will be the responsibility of the client and/or their family.
9. Each individual program shall orient clients to specific requirements upon admission. The above rules and expectations are to aid the client's recovery.

FACILITY

1. Exit route diagrams are located in the hallways, group rooms, and counselor's offices. These diagrams identify exit routes, the location of First Aid Kits, and fire extinguishers.
2. In case of emergencies (i.e., fire, tornado, equipment failure); please follow the directives provided by staff on site.
3. For safety purposes, always remember to sign in upon entering and sign out upon exiting the Benchmark Integrated Health facility. The Sign In/Out Log is located at the receptionist's desk.
4. To reduce the disruption of service, please limit cell phone use for emergencies only during group/individual programming.
5. To reduce the spread of illnesses, please remember to wash/disinfect your hands.
6. There is no loitering permitted on Benchmark Integrated Health properties.

TERMINATION

The following will constitute grounds for termination from the facility:

7. Selling/ Distributing drugs on the premises.
8. Abuse of drugs, intoxication, or alcohol on the premises.
9. Violence or threats of violence on or about the premises. Possession of weapons on the premise.
10. The use of abusive language toward staff.

You have the right to an administrative review of any action to terminate you from treatment. Upon notification, by a clinical supervisor, of pending termination, you will automatically receive an appointment for your appeal. You will forfeit your right if you fail to appear on the date and time of your hearing.

Behavior that undermines treatment rules and expectations will not be tolerated. Violation of these rules will result in consequences and may result in dismissal from the program. Illegal activity is subject to criminal prosecution.

If after 30 days a client should desire to regain rights/access to services that have been restricted or terminated at Benchmark Integrated Health, he/she, (along with his/her Parent/Guardian when appropriate) may do so by submitting in writing or by making a verbal formal request to his/her most recently assigned Benchmark Integrated Health staff member. Benchmark Integrated Health will utilize a team Case Review facilitated by the service line's Clinical Director to review lifting the restrictions. If not informed already, Benchmark Integrated Health will then inform the most recently assigned Benchmark Integrated Health staff member of the Case Review findings, and, consequently, work directly with the Client (along with his/her Parent/Guardian when appropriate) to assist with service access or alternative service agency.

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Name: _____ **Date:** _____

Guardian Name: _____ **Date:** _____

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Confidentiality Policy

Counseling and treatment are personal and confidential relationships between a clinician and an individual, group, or family.

At Benchmark Behavioral Health, we work from a team approach. Therefore, there may be times when it is necessary for us to consult with other professional staff, either individually or during our clinical team meetings, to provide you with the highest consideration and quality of care. Our clinicians are all Master's-prepared and professionally licensed, graduate students, interns, or clinicians working toward certification in substance abuse counseling.

No information will be released from Benchmark Behavioral Health regarding counseling or consultation sessions without your express written consent. If you wish for information to be released to anyone, it will be necessary for you to complete a Release of Information form, specifying to whom the information is being released. The law stipulates that in the event of imminent danger to yourself or others, we must breach confidentiality. We must also act in accordance with any applicable State laws regarding mandatory disclosure of child, elderly, or other abuse.

Satisfaction Survey

Your satisfaction is key to our success. We want to hear what you find good about our services and where we need to improve. Periodically, we will distribute a satisfaction survey for you to fill out. Your signature is optional.

I have read the above policies and procedures and understand them.

Name: _____ **Date:** _____

Guardian Name: _____ **Date:** _____

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Group Confidentiality

To reinforce feelings of closeness and a willingness to share your feelings, thoughts, and the consequences of your dependency, confidentiality is paramount in group therapy. Use this as your golden rule: What is said in Group, stays in Group. Breaking this rule violates the trust of the entire group and undermines the effectiveness of group therapy.

The following guidelines will help you maintain this rule:

1. Group issues are not discussed with anyone outside your group.
2. Do not discuss group issues with your roommate unless they are in your group.
3. Do not discuss group issues at outside meetings or places where others may overhear you.

Your group therapists have the same responsibilities for group confidentiality as you do, with the exception that your therapists may share group issues and your participation in the group process with other staff members. This is a vital part of the staff team's approach to assist you in your recovery.

The staff values your confidentiality so highly that anyone who breaks confidentiality—whether to another patient of Benchmark Behavioral Health, or to family, significant others, etc.—may be subject to discharge from this program.

Name: _____ **Date:** _____

Guardian Name: _____ **Date:** _____

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FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing **Benchmark Integrated Health** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our Client Financial policies.

Client Financial Responsibilities

- The Client (or Client's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the Client is required to provide the most correct and updated information regarding insurance. If we are unable to process payment through your insurance for any reason, we will bill you for the services provided at the following rates:

1.	Individual Psychotherapy	1-hour Session	$ 100.00
2.	Group Psychotherapy	1-hour Session	$ 75.00
3.	Family Psychotherapy	1-hour Session	$ 75.00
4.	Diagnostic Evaluation	Flat fee	$ 150.00
5.	Community Psychiatric Supportive Treatment	1-hour Session	$ 45.00
6.	Therapeutic Behavioral Services	1-hour Session	$ 45.00
7.	Psychosocial Rehabilitation	1-hour Session	$ 45.00
8.	Assertive Community Treatment	1-hour Session	$ 95.00
9.	Intensive Home-Based Therapy	1-hour Session	$ 95.00
10.	Substance Use Disorder Assessment & ASAM	Flat fee	$ 70.00
11.	Substance Use Disorder Services	1-hour Session	$ 75.00
12.	Intensive Outpatient Treatment	Hourly Rate	$ 95.00
13.	Medication Management	Flat Fee	$ 70.00

- Clients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan
- Copays are due at the time of service
- Coinsurance deductibles and non-covered items are due 30 days from receipt of billing
- Clients may incur, and are responsible for payment of additional charges, if applicable. These charges may include: Charge for returned checks - $40.00

By my signature below, I hereby authorize assignment of financial benefits directly to **Benchmark Integrated Health** and any associated healthcare entities for service rendered as allowed under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Client Acknowledgement and Authorization

We respect Client confidentiality and only release personal health information about you in accordance with the State and Federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully. By my signature below, I acknowledge that I have received and read the privacy notice provided by **Benchmark Integrated Health** to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and or other physicians or healthcare entities to participate in my care.

Client Name

Client/Legal Guardian Signature **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF:

1. Consumer Rights Policy and DMH Consumer Rights Statement; and
2. HIPAA Privacy Rules for the Protection of Health and Mental Health Information

I acknowledge that I received:

_____ Consumer Rights Policy and DMH Consumer Rights Statement

_____ HIPAA Privacy Rules for the Protection of Health and Mental Health Information

My signature below acknowledges that I have received a copy of both the **Benchmark Integrated Health Consumer Rights Policy** and the **DMH Consumer Rights Statement** and that I have received a copy of the **HIPAA Privacy Rules for the Protection of Health and Mental Health Information**.

Client Name (Printed): _____

Client Signature: _____

Parent/Legal Guardian Signature: _____

Date: _____

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STATEMENT OF PROVIDER CHOICE

I have selected to receive the following service(s) from **Benchmark Integrated Health**:

Check all that Apply:

- ☐ Diagnostic Evaluation and Diagnostic Evaluation Update
- ☐ Community Psychiatric Service Treatment (CPST)
- ☐ Psychotherapy (Individual, Family, Group, Crisis)
- ☐ Psychoeducation Support Services (Therapeutic Behavioral Services, Psychosocial Rehabilitation)
- ☐ Assertive Community Treatment (ACT)
- ☐ Intensive Home-Based Therapy (IHBT)
- ☐ Substance Use Disorder Assessment and ASAM
- ☐ Substance Use Disorder Services (Case Management; Psychotherapy; Individual Counseling; Group)
- ☐ Intensive Outpatient Treatment
- ☐ Laboratory Analysis
- ☐ Medication Management

I attest that I have been provided with the information necessary to make an informed choice about service, informed about the range of other services in a way that in non-coercive and protects my right to self-determination.

My selection of a service provider was based solely upon my identified needs, diagnosis, preference and provider availability.

By signing this Statement of Provider Choice, I acknowledge that I was given choice of provider and that the screening discussed location, available times, specialty, culture and linguistic preferences with me.

_____

Client Name (Printed)

_____ _____

Client Signature **Date**

_____ _____

Parent/Legal Guardian Signature **Date**

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Release of Confidential Information

I, _____, hereby give my consent for the release of confidential information pertaining to my personal records and treatment. I understand and acknowledge that this information may include, but is not limited to, medical records, assessments, treatment plans, progress notes, and other related documentation.

Recipient of Information:
Name of Individual/Organization: Benchmark Integrated Health
Address: 3829 Woodley Rd B6
Toledo, OH 43606
Phone Number:
Fax: 419-690-4544
Email Address: Admin@benchmarkih.com

Purpose of Release:
The confidential information is being released for the purpose of [, coordinating care, assessment, treatment, legal proceedings, etc.].

Information to be Released:
I authorize the release of the following specific information:

- ☐ Biopsychosocial Assessment
- ☐ Psychological assessment
- ☐ Psychiatric history and assessment
- ☐ Results of physical exam
- ☐ Medical history/current
- ☐ Laboratory test results
- ☐ Treatment Plan
- ☐ Presence in treatment
- ☐ Addiction Services Treatment
- ☐ Employment information
- ☐ Legal status
- ☐ Family information
- ☐ Aftercare recommendations
- ☐ Discharge planning
- ☐ Discharge summary
- ☐ Other_____

Duration of Consent:
This consent is valid for the period from [Start Date_____] to [End Date_____] or until [Specific Event, e.g., the completion of treatment, resolution of legal matter, etc.], whichever occurs earlier. If no end date is specified, this consent will remain in effect until revoked in writing.

Revocation of Consent:
I understand that I have the right to revoke this consent at any time by providing a written request to the [Your Facility/Organization Name]. I understand that revocation of consent will not affect any actions taken prior to the receipt of my written revocation.

Limits of Consent:
I understand that this consent for release of information does not extend to any information protected under federal or state laws, including but not limited to substance use treatment records and HIV-related information. Such information will not be released without separate written authorization.

(Under the Mental Health Code, the release of mental health records must be germane to the purpose and need for disclosure.)

- ☐ Continuity of treatment - Patient history - Case Management services
- ☐ Emergency contact - General Updates
- ☐ Court services - Legal purposes - Probation - Disability claiming - Unemployment claiming - Employment continuity.

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my verbal or written consent unless otherwise provided for in the regulations. 42 CFR part 2 prohibits unauthorized disclosure of these records. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS), and/or related conditions.

I understand that I may revoke this authorization at any time upon verbally or with written notice to Benchmark Integrated Health. I acknowledge that such revocation will not be effective if Benchmark Integrated Health has already acted in reliance upon this authorization. This authorization is valid (if not previously revoked) this consent will terminate upon 365 days from the date of signature of this form, or the following event/condition: or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.

Signature of Client	**Printed Name**	**Date**
Signature of Parent/Legal Guardian/ Personal Representative**	**Printed Name**	**Date**

** Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute and alcohol or drug abuse client. ** If other than client's signature, a copy of legal paperwork verifying the client's personal representative MUST accompany the request unless otherwise on file with provider (e.g., court appointed guardian, durable power of attorney for healthcare, grandparent power of attorney). Exception: Parent signing for client under the age of eighteen and the County agency holding custody.*

Revocation of Authorization for Release of Information

At the date and time noted below, I hereby revoke permission for Benchmark Integrated Healthcare to further release information to the above-noted person, except to the extent the program has already acted in reliance upon it.

Signature of Client/Parent/Legal Guardian/ Personal Representative**	**Date**

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Transportation Release and Waiver of Liability

Notice: This form contains a release and waiver of liability and, when signed, is a contract between the undersigned Client and Benchmark Integrated Health with legal consequences. Please read this agreement in its entirety carefully before signing your name. This form must be signed in the presence of a witness who should also sign as a witness.

Client's Information:

Activities: This includes, but is not limited to, transportation from and to the client's residence, the facility, medication pick-up, school, stores, medical appointments, etc.

Date of Execution of Release and Waiver of Liability: _____

The undersigned agrees that this Release and Waiver of Liability agreement is valid from the date of execution through the date of discharge from Benchmark Integrated Health.

Name of Facility: Benchmark Integrated Health
Client's Full Name: _____
Parent/Guardian's Full Name: _____
Client/Parent/Guardian Phone Number: _____
Name and Telephone Number of Emergency Contact: _____

Acknowledgements and Representations by Client:

The undersigned Client, _____, is currently a client at Benchmark Integrated Health and will be participating in the Transportation services provided by Benchmark Integrated Health. This includes, but is not limited to, transportation from and to the client's residence, the facility, medication pick-up, school, stores, medical appointments, etc.

The undersigned Client, _____, (or parent/guardian of the individual named herein) knowingly, freely, and voluntarily assumes all liability for any and all damages or injuries that may occur as a result of his/her (or his/her dependent's) participation in the activities described herein. The Client agrees to release, waive, discharge, and covenant not to bring suit against Benchmark Integrated Health, its officers, agents, employees, and volunteers for any and all liability or claims that may be sustained by the Client or by a third party, directly or indirectly, in connection with or arising

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out of his/her (or his/her dependent's) participation in the activities described herein, whether caused in whole or in part by the negligence of Benchmark Integrated Health or otherwise.

The undersigned Client, _____, (or parent/guardian of the individual named herein) has read the form, fully understands its terms, and acknowledges that he/she (or his/her dependent) has given up substantial rights by signing it. The Client has signed it freely and without inducement or assurance of any nature and intends it to be a complete and unconditional release of all liability to the greatest extent allowed by law. The Client agrees that if any portion of this contract is held to be invalid, the balance shall continue in full legal force and effect.

Indemnification of Benchmark Integrated Health:

The undersigned Client (or his/her parent/guardian) shall at all times indemnify, hold harmless, and, at Benchmark Integrated Health Attorney's option, defend or pay for an attorney selected by the Board to defend Benchmark Integrated Health, its officers, agents, servants, and employees against any and all claims, losses, liabilities, and expenditures of any kind, including attorney fees, court costs, and expenses, caused by the negligent act or omission of the Client, other clients of Benchmark Integrated Health, its employees, agents, servants, or officers, or resulting from or related to the undersigned Client in situations including, but not limited to, transportation to and from the facility, medication pick-up, medical emergencies, and transportation to the nearest mental health receiving facility. This includes any and all claims, demands, or causes of action of any nature whatsoever resulting from injuries or damages sustained by any person or property. The provisions of this section shall survive the expiration or earlier termination of this agreement, or the discharge of the Client from the Partial Hospitalization or Intensive Outpatient Program facility operated by Benchmark Integrated Health.

Venue: This Agreement shall be interpreted, constructed, and governed by the laws of the State of OHIO. Venue for litigation concerning this agreement shall be in LUCAS County.

By signing this, I agree that I have read and understand the contents herein.

Name: _____ **Date:** _____

Guardian Name: _____ **Date:** _____

Witness: _____ **Date:** _____

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UNIVERSAL PRECAUTIONS FOR INFECTION CONTROL

Universal Precautions refer to the usual and ordinary steps you need to take in order to reduce the risk of infectious diseases such as Hepatitis C, HIV the virus that causes AIDS, and COVID-19. These measures are intended to prevent transmission of Hepatitis C, HIV, or COVID-19. The prevention of transmission of infectious diseases is based on the avoidance of skin and mucous membrane contact with blood or other body fluids, coughing, sneezing, and touching.

AVOID UNNECESSARY RISKS

- If a fellow patient or client needs assistance, please call a staff member immediately.
- When avoidable, don't expose yourself to other people's blood or body fluids.
- Never share needles, razors, or any other *personal* sharp objects.
- Always call on trained individuals to clean up blood or other body fluid spills.
    - Avoid risky behavior
    - Protect yourself from sharp objects
    - Practice social distancing (6 feet from one another)
    - Wear gloves when in contact with body fluids if possible
    - Always wear masks
    - Wear mask and eye protection when splash injuries are possible
    - Call on trained individuals to clean up blood spills to protect yourself from HIV

PROTECT YOURSELF

- Use barrier protection to prevent skin and mucous membrane contact with blood and other body fluids.
- Wear face protection if blood or body fluid droplets may be generated during a procedure.
- Wear protective clothing if blood or body fluids may be splashed during a procedure.
- Clean your hands often, either with soap and water for 20 seconds or a hand sanitizer that contains at least 60% alcohol.
- Wash hands immediately after gloves are removed.
- Avoid close contact with people who are sick.
- Cover your mouth and nose with a cloth face cover when around others.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces daily.
- Use care when handling sharp instruments and needles. Place used sharps in labeled, puncture-resistant containers.
- If you have sustained an exposure or puncture wound, immediately flush the exposed area and notify a staff member.

Name: _____ **Date:** _____

Guardian Name: _____ **Date:** _____

BENCHMARK INTEGRATED HEALTH

3829 Woodley Rd, Suite B6, Toledo, OH 43606

Office: 419-690-4544
Web: www.benchmarkih.com

DRUG & ALCOHOL USE POLICY

I, _____ hereby agree to participate fully in all aspects of my treatment while at Benchmark Integrated Health.

I understand that while I am in treatment at Benchmark Integrated Health, I am expected to:

Please initial the following statements:

- _____ I understand that if I am prescribed any medication by any provider, I am expected to inform my attending clinician immediately.
- _____ Abstain from the use of all illegal/non-prescribed substances and alcohol.
- _____ I understand that frequent and random urinalysis and random breathalyzers are part of substance abuse treatment.
- _____ I agree to provide a urine sample and/or breathalyzer upon request.
- _____ I understand the refusal to provide a urinalysis or a breathalyzer when requested will be considered positive and may lead to discharge from the program.
- _____ I understand that absolutely no alcohol, drugs, or drug paraphernalia is permitted on the premises. I understand that anyone suspected of being under the influence of drugs or alcohol or who possesses any illicit drugs or alcohol may be required to leave the program immediately.
- _____ I understand that I cannot wear any clothing that glorifies or endorses the use of alcohol or drugs.

The above conditions have been explained to me and I fully understand my obligations while in treatment at Benchmark Integrated Health and agree to abide by the conditions stated above.

Name: _____ **Date:** _____

Witness: _____ **Date:** _____

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WRITTEN SUMMARY OF FEDERAL REGULATION: CONFIDENTIALITY OF ALCOHOL & OTHER DRUG ABUSE CLIENT RECORD (42 C.F.R)

In accordance with 42 C.F.R., the confidentiality of client records related to alcohol and other drug services is strictly maintained under the following conditions:

- **Disclosure Restrictions:** Program staff shall not inform anyone outside the program that a client receives services or disclose any information identifying a client as an alcohol or other drug services client unless:
  - The client provides written consent for the release of information.
  - The disclosure is permitted by a court order.
  - The disclosure is made to qualified personnel for a medical emergency, research, audit, or program evaluation purpose.

- **Criminal Activity:** Federal laws and regulations do not protect any threats to commit a crime or any information about a crime committed by a client either at the program or against any person who works for the program.

- **Child Abuse or Neglect:** Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to the appropriate State or Local authorities.

This agency complies with these confidentiality requirements to ensure the privacy and protection of our clients' information.

Name: _____ **Date:** _____

Guardian Name: _____ **Date:** _____