

# Patient Handbook



*At North Tampa Behavioral Health our mission is to provide Help for Today and Hope for Tomorrow.*

**W**elcome!

The administrative and clinical staff of North Tampa Behavioral Health would like to welcome you to our program. North Tampa Behavioral Health will do everything within its power to make your stay a beneficial and rewarding experience. We encourage you, and with your permission, your families to ask questions, express any concerns you may have and most importantly to take full advantage expertise North Tampa Behavioral Health has to offer. Active participation in the design of your individualized treatment and taking full advantage of all of our programs is paramount to your growth and outcomes. We will make every attempt to accommodate individual needs and respect the established routines of our patients. If there is anything we can do to make your stay more comfortable, please do not hesitate to ask.

North Tampa Behavioral health is sensitive to persons who are limited in English proficiency, and has available interpreters, written translation, bilingual staff, and a telephone system (at no cost to the patient) to assist in communication. Information on interpreters and interpreter service is posted on unit program community boards, hospital bulletin boards, and brochures.

## **WHAT TO EXPECT**

You will be greeted and supported by a comprehensive clinical team of health care professionals. The team leader will be your specific psychiatrist. Your psychiatrist or their designee will schedule individual contact with you as needed. Your psychiatrist will evaluate your mental processing and behavior. Depending on your needs, a comprehensive individualized treatment plan will be developed on how we can assist you with dealing with your identified areas of concern. You will also receive a physical exam within the first 24 hours of your stay by one of our staff physicians or their designee. The doctor may order tests such as additional tests based on assessed need.

As part of your clinical team, a nurse will be interviewing you regarding your health history and the reasons for this admission. You will also see a social worker (or case manager) who will work with you and your family to determine how we can best help you during your stay with us as well as after you are discharged.

Your stay at North Tampa Behavioral Health will be very busy with all activities (programmatically and individualized) specifically designed to assist you in better understanding your individual needs and to assist you in identifying and learning 'tools' to be better able to deal with your specific life circumstances.

## **Some of our activities may include:**

**Group Therapy:** These groups are led by professionally trained clinical therapists, nurses and other qualified staff. This is a safe place where you can discuss issues that matter to you and receive information regarding the problems you face.

**Family Meetings:** We want your family involved in your care (if you wish). This is a time when we can meet with you and your family to discuss issues that are important to you and gain knowledge to assist you and us in making decisions for your future.

**Recreational Activities:** These are activities that will assist you in concentration and/or movement. These activities are geared to improve memory as well as teach you new skills or polish up on old ones. You can also learn new ways to use your time when leaving the hospital. Our facility features an indoor gym as well as an outdoor courtyard with full basketball court. Recreational therapy is overseen by licensed recreation therapists. During your stay, please understand that your safety is our top priority. While most of the recreation activities can be completed by most individuals we ask that you alert staff to any health risks or concerns you have, prior to participation in recreation therapy. Participation in these activities is to be done at your own risk.

**Health teachings:** The nursing staff will discuss health problems you may be facing, your current medication and how to take it and any other health issue you may have. It is very important that you attend and actively participate in all the planned activities specifically designed for you. Participation will enhance and assist you to obtain the full benefit of what North Tampa Behavioral Health has to offer.

You will see your psychiatrist and/or a member of your clinical team daily. At least every three days a formal "Treatment Team Meeting" will take place to discuss and adjust your individualized treatment plan. You are a very important member of this treatment team. This is one of the times when all of the clinical staff, (i.e. Psychiatrist, Social Worker, Nurse Etc.), meet with, and/or for, you to discuss your progress and plans for the future. North Tampa Behavioral Health believes that the unit atmosphere must be comfortable, respectful and as realistic like as possible. For this reason, we encourage you to do as much as you can independently regarding your own care. We also try to keep our environment as neat as possible and will ask for your help in this.

# What You Will Need While in the Hospital

## Clothing and Toiletries

You will be wearing comfortable, casual, street clothes during the day and bed clothes for night. Please have no more than two to three days of clothing change with you. A washer and dryer are available for your use or your family can care for your clothing. We ask that you do not bring expensive clothing to the hospital. You may bring your own toiletries, if you wish, as long as they are alcohol-free and contain no sharp edges. Anything that you do not bring with you can be provided. Other special items you wish to bring should be cleared with the nursing staff. We do ask that toiletries not be in glass containers. When you are admitted, the staff will take an inventory of your belongings with you and ask you to sign a completed inventory form. This is to help you and the staff keep track of your things. We can also advise you of what items you can keep in your room and which items we will hold for you. For example, items in glass containers will be kept by the staff and given to you at the time of use. This is for safety reason. We also recommend lace-free shoes during your stay.

## Jewelry and Other Valuables

The hospital does not take responsibility for jewelry, money and other valuable items. For this reason, we ask that you leave these at home or in the care of friends or relatives. You will not need spending money during your stay in our facility.

## Personal Items

If you have hobbies or like to read, you are welcome to bring in paperback books or other personal items that will make you feel more at home. Other personal items you wish to bring should be cleared with the nursing staff. Some items that may not be allowed into the facility include, but are not limited to: tablets, cellphones, computers, cameras, glass containers, belts, shoelaces, jewelry, medication, writing utensils, outside food and drink, unwrapped cigarette containers, chewing tobacco, some e-cigarettes, illicit substances, drug paraphernalia, aerosol containers, nail clippers, nail files, fingernail polish, steel toe work boots, lighters, matches, stuffed animals, some hygiene products, explicit photographs, explicit literature, sharp edged object, or any weapons. If items are present, family will be asked to take them home or the items will be placed within a secured locker/cabinet. Any additional items will be appropriately labeled and stored in a secure patient inventory room and returned to the patient upon discharge.

## Room Orientation

Once inside your room, become familiar with your surroundings. Your rooms are designed to be comfortable and functional. Please remember that your stay at North Tampa Behavioral Health is to better understand your thinking and behavior in a safe and respectful environment, therefore we discourage you isolating in your room while not in active programming.

## Smoking

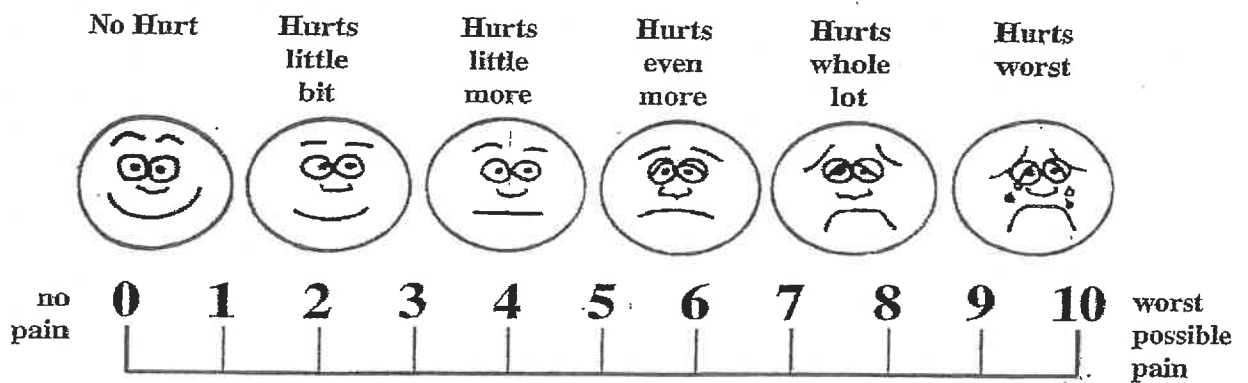
While this facility does permit patients to use tobacco products on premises, we ask that you please arrive only with unopened wrapped tobacco products.

## Pain Management

Patients have the right to have their pain assessed, reassessed, treated, and evaluated as appropriate. Patients and families will be provided with the necessary education during their course of treatment and at discharge.

Upon admission to the inpatient unit, a registered nurse will screen you for pain. If pain is present, we will ask you about the pain; where it is, how often you have it, how long it lasts, what it is like etc. If you have no pain present at time of admission, you can request a pain assessment at any time during your stay.

The following is the scale which will be used in order to assess your pain:



## **Falls Protocol/ Patient Safety**

Providing a safe environment for our patients is a priority at North Tampa Behavioral Health. Fall prevention is a key component of the safe environment.

Upon admission, you will be asked a series of questions in order to determine your risk for falls. If you are assessed to be a high fall risk, we will take extra precautions to keep you safe and free of falls during your stay. In order to help minimize the risk for falls, the following actions will be implemented:

- ❖ Adequate footwear when you are up and walking
- ❖ Side rails up (no more than 3 side rails at one time)
- ❖ Use of wheelchairs and assistive devices for mobility
- ❖ Assistance to the bathroom and to and from wheelchair
- ❖ Call button within reach
- ❖ Use of monitor alarms for safety

North Tampa Behavioral Health is committed to providing a safe and healthful environment. Our policy is to prevent the exposure of our employees, patient's, and visitors to health and safety risks. Each employee is expected to work diligently to maintain safe, healthful working conditions and to adhere to proper operating practices and procedures designed to prevent injuries and illnesses.

North Tampa Behavioral Health strives to be a restraint free environment. Our philosophy recognizes that all patients have a right to considerate, respectful care at all times, with recognition of their personal safety, dignity, rights, and wellbeing. Restraints will be used only as a last resort, and only when less restrictive measures have been found to be ineffective to protect the patient or others from harm. Restraints may only be used with the order of a physician.

## **Medication Education**

Upon admission, the nurse will explain to you your medications and any side-effects you may experience with the medications. Throughout your stay at North Tampa Behavioral Health, there will be daily health education groups led by the nurse who will provide you with information on both health problems and on medications. Feel free at any time to request a

topic of concern related to your health or medications. We are here to better inform you of any health problems and medication side-effects you may have.

## **Treatment Planning**

A multi-disciplinary team is responsible for planning your treatment process during your stay at North Tampa Behavioral Health. Those involved in the treatment planning process may include your physician, nursing staff, Social workers, mental health technicians, and activity therapists. This team is responsible for developing an individualized treatment plan which will include reviewing and evaluating your treatment and progress.

## **Discharge Planning**

The process of discharge planning involves you and your family, the multi-disciplinary team, your attending physician, and any community resources you may be using or we might recommend.

A member of the clinical staff, Social Worker or Utilization Review Case Manager, will coordinate the discharge planning process, involving you and your family either through treatment planning meetings, family sessions, or telephone communication. Discharge instructions will be provided and explained, by a member of the nursing staff, with you and your family if requested, prior to discharge.

North Tampa Behavioral Health is dedicated to delivering the highest quality of mental health care to our patients and their families. As you and your family face life-changing decisions, it is our hope that the staff of we can offer the support and encouragement to make these decisions with greater assurance. We welcome any questions, comments, and criticisms that you may have of our program as we continue in our pursuit of excellence.

## **Restraint and Seclusion Philosophy**

The staff at North Tampa Behavioral Health is committed to creating an environment that minimizes circumstances that give rise to the use of restraint and seclusion techniques, and that maximizes safety when they must be used. Our approach seeks to prevent, reduce, and strive to eliminate any use of restraint or seclusions and, when they must be used, protect the client's health and safety, while preserving his or her dignity, rights, and well-being.

## **Damage to Property**

In the case of intentional or malicious damage caused to the property or structure of this facility, the individual responsible may be billed for the repair or replacement of said damages.

## **Physician Availability**

North Tampa Behavioral Physicians are on call, available via phone 24 hours a day. Physicians are on site daily. Physicians may not be available on site immediately during non-business hours.

## **Advance Directives**

NTBH honors all Psychiatric and Mental Health Advanced Directives. Advance Directives relating to all medical crises are referred to medical treatment facilities. Life-saving measures may be performed on a patient, regardless of any form of Advance Directive, to stabilize a patient and transfer to a medical treatment facility.

## **PATIENT AND FAMILY GUIDE TO HEALTH CARE SAFETY**

Health care organizations across the country are working to make health care safe. You, the patient, as well as the doctors, health care executives, nurses and health care technicians have a role in making your health care safe. You can make your care safer by being an active, involved and informed member of the health care team. This guide gives simple advice on how you can help make health care a good experience. To help prevent health care mistakes, patients are encouraged to ask questions.

If you have questions or concerns, speak up! Ask the question again, if you don't understand. You have a right to know about your treatment.

- ❖ If you don't understand something that your doctor, nurse or health care professional tells you, don't worry about being embarrassed; speak up.
- ❖ Don't be afraid to ask about safety.
- ❖ Don't be afraid to tell the nurse or doctor if you think you are about to get the wrong medicine, or a food or medication that you are allergic to.

- ❖ If you think a health care professional has confused you with another patient; don't be afraid to speak up.

You can make sure you are getting the right treatments and medicines by the right health care professional by paying attention to the care you get.

- ❖ If something doesn't seem right; tell your nurse or doctor.
- ❖ Health care workers should wear an identification (ID) badge and should introduce themselves to you. If you don't know who the person is, ask for their ID.
- ❖ Hand washing is the most important way to prevent infections. Notice whether your caregivers have washed their hands. Don't be afraid to remind your caregiver to do this.
- ❖ Make sure your nurse or doctor checks your ID wristband and asks your name before he/she gives you your medicine or treatment.

Learn about your illness and treatment plan.

- ❖ Information about your condition may be obtained from your doctor, your library, respected websites and support groups.
- ❖ Write down important facts your doctor tells you.
- ❖ Make sure that you read and understand all medical forms before you sign anything. Ask your doctor or nurse to explain them to you, if you don't understand.

Know what medicines you take and why you take them.

- ❖ Ask questions about your medication; why you should take the medication, its generic and brand names and any side effects.
- ❖ If you don't recognize a medication, double-check that it is meant for you. Ask about medications before you swallow them.
- ❖ If you are given an IV, tell the nurse if it doesn't seem to be dripping correctly (too fast or too slow).
- ❖ Tell your doctors and nurses about any allergies you have or any negative reactions you have had to other medicines
- ❖ Ask your doctor or pharmacist if it is safe to take vitamins, herbs and over-the counter drugs with your prescription medications.

Check out a hospital, clinic, surgery center or other type of health care organization before using that facility.

- ❖ Ask questions about the health care organization's experience in performing the procedure that you need or in taking care of people with your type of illness.
- ❖ Find out whether your hospital or other health care organization is "accredited. This means that the hospital or health care organization works by rules that make sure the patient safety and quality standards are followed.

You are the center of the health care team; so, participate in all decisions about your treatment.

- ❖ Know who will be taking care of you; how long the treatment will last and how you should feel.
- ❖ You and your doctor should agree on what will be done during each step of your care.
- ❖ Don't ever be afraid to speak up!

## Patient Information on Advance Directives

### DECIDING ABOUT YOUR HEALTHCARE

If you are 18 or older, the law says you have the right to decide about your medical care. If you are very sick or badly hurt, you may not be able to say what medical care you want. If you have an *advance directive*, your doctor and family will know what medical care you want if you are too sick or hurt to talk or make decisions.

### WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is used to tell your doctor and family what kind of medical care you want if you are too sick or hurt to talk or make decisions. If you do not have one, certain members of your family will have to decide on your care.

You must be at least 18 years old to set up an advance directive. You must be able to think clearly and make decisions for yourself when you set it up. You do not need a lawyer before you take this important step. Whether or not you have an advance directive, you have the same right to get the care you need.

### TYPES OF ADVANCE DIRECTIVES

In Florida you can set up an Advance Directive for Health Care. The choices you have

include:

- ❖ A LIVING WILL a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions or are too sick to speak for
- ❖ A HEALTH CARE SURROGATE DESIGNATION can be part of a living will. You can designate a health care surrogate to speak for you and make the choices you would make if you could. You can also designate an alternate health care surrogate in case your first choice is unable to fulfill their role. If you pick a health care surrogate, you should talk to that person ahead of time. Be sure that your health care surrogate knows how you feel about different kinds of medical treatments.
- ❖ As an alternative to a health care surrogate, or in addition to, you might want to designate a DURABLE POWER OF ATTORNEY. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

You can choose to have any or all of these advance directives: Living Will, Health Care Surrogate Designation and/or Durable Power of Attorney. Hospitals, home health agencies, hospices, and nursing homes usually have forms you can fill out if you want to set up a living will or designate a health care surrogate. If you have questions, you may wish to speak with your Primary Care Provider, lawyer and/or significant person in your life.

### **WHEN YOU SET UP AN ADVANCE DIRECTIVE**

Be sure to sign your name and write the date on any form or paper you fill out. Talk to your family and doctor now so they will know and understand your choices. Give them a copy of what you have signed or inform them of where a copy is kept. If you go to the hospital, give a copy of your advance directive to the person who admits you to the hospital.

## **WHAT DO I NEED TO DECIDE?**

You will need to decide if you want treatments or machines that will make you live longer even if you will never get better. An example of this is a machine that breathes for you. Some people do not want machines or treatments if they cannot get better. They may want food and water through a tube or pain medicine. With an advance directive, you decide what medical care you want.

## **TALK TO YOUR DOCTOR AND FAMILY NOW**

The law says doctors, hospitals and nursing homes must do what you want or send you to another place that will. Before you set up an advance directive, talk to your doctor ahead of time. Find out if your doctor is willing to go along with your wishes. If your doctor does not feel he or she can carry out your wishes, you can ask to go to another doctor, hospital or nursing home. Once you decide on the care you want or do not want, talk to your family. Explain why you want the care you decided on. Find out if they are willing to let your wishes be carried out.

Family members do not always want to go along with an advance directive. This often happens when family members do not know about a patient's wishes ahead of time or if they are not sure about what has been decided. Talking with your family ahead of time can prevent this problem.

## **YOU CAN CHANGE YOUR MIND ANY TIME**

As long as you can speak for yourself, you can change your mind any time about what you have written down. It is recommended that any changes be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive. Give copies of any new forms or changes to everyone who needs to know.

## **FOR HELP OR MORE INFORMATION:**

Florida Agency for Health Care Administration: 888-419-3456

## **Rights of Persons in Mental Health Facilities and Programs**

The following rights are guaranteed to you under Florida law. These will be fully explained to you at the time of and following admission to this facility. A copy of this form will be given to you to keep. You have the right to read the Baker Act law and rules at any time. Your signature on the form, if you choose to sign, only acknowledges that you have had the rights explained and that a copy of this form was provided to you.

### **Nondiscrimination**

North Tampa Behavioral Health does not exclude or discriminate against patients who present for admission and during treatment in all levels of care on the basis of race, color, age, creed, gender, religion, national origin, physical capability/disability, sexual orientation, socioeconomic status, political affiliation or veteran status.

### **Individual Dignity**

You have the right to individual dignity and access to all constitutional rights. The Federal Americans with Disabilities Act (ADA) applies to persons in this facility.

### **Right to Request Discharge by Persons on Voluntary Status**

If you request discharge, your doctor will be notified and you will be discharged within 24 hours from a designated community facility and within 3 working days from a state hospital, unless you withdraw your request or you meet the criteria for involuntary placement. If you meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the hospital administrator must file a petition with the Court for your continued stay within two (2) working days of your request for discharge.

### **Designation of Representative**

You will be asked to identify a person to be notified in case of an emergency. Further, if you are at this facility for involuntary examination and do not have a guardian appointed by the court, you will be asked to designate a person of your choice to receive notification of your presence in this facility, unless you request that no notification be made. If you do not or cannot designate a representative, a representative will be selected for you by the facility from a prioritized list of persons. You have the right to be consulted about the person selected by the facility and you can request that such a representative be replaced.

## Communication

You have the right to communicate openly and privately by phone, mail, or visitation with persons of your choice during your stay at this facility. You have the right to make free local calls and will be given access to a long distance service for collect calls. If communication is restricted, you will be given a written notice including the reasons for the restrictions. This facility is required to develop reasonable rules governing visitors, visiting hours, and the use of telephones but you cannot be limited in your access to your attorney, to a phone for the purpose of reporting abuse, in contacting the Florida Local Advocacy Council or the Advocacy Center for Persons with Disabilities. Several toll-free telephone numbers you may wish to keep are:

- Florida Abuse Registry: 1 800 96-ABUSE or (800) 962-2873
- Florida Local Advocacy Council 1 800 342-0825
- Advocacy Center for Persons with Disabilities 1 800 342-0823

## Confidentiality of Information and Records

Information about your stay in this facility is confidential and may not be released, except under special circumstances, without your consent (or the consent of your guardian or guardian advocate or health care surrogate/proxy if you have one). Special circumstances include release of information to your attorney, in response to a court order, to an aftercare treatment provider, or after a threat of harm to another person. You have the right of reasonable access to your clinical record unless such access is determined to be harmful to you by your physician.

## Treatment

You have the right to receive the least restrictive, available, appropriate treatment in this facility. You will get a physical examination within 24 hours of arrival and you will be asked to help develop a treatment plan to meet your individual needs. The criteria, procedures, and required staff training used by this facility for restraints, seclusion, isolation, emergency treatment orders, close levels of supervision, or physical management are available for your review. Such interventions may never be used for punishment, convenience of staff, or to compensate for inadequate staffing.

## North Tampa Behavioral Health

This is to inform you of your right to place a complaint/grievance at North Tampa Behavioral Health. In the event that you have a complaint that has not been resolved by the healthcare staff at the time of your complaint and you wish to file a grievance, you may do so by letter, or in person (address below):

### **Patient Advocate: Darci D.**

North Tampa Behavioral Health  
29910 SR 56  
Wesley Chapel, FL 33543

Filing a grievance will not subject you to any form of adverse action or jeopardize your future access to North Tampa Behavioral Health. Your grievance will be reviewed and investigated, and you will receive a written response within seven (7) days of receipt of the grievance.

### **How to Report a Complaint**

For questions or information, you may contact the Agency for Health Care Administration (AHCA) or by phone toll-free at (888) 419-3456, or by mail at:

Agency for Health Care Administration  
2727 Mahan Drive  
Tallahassee, FL 32308

To report the details about your complaint to The Joint Commission, use one of the following options:

E-mail: [complaint@jointcommission.org](mailto:complaint@jointcommission.org)

Fax: 630-792-5636

Mail: Office of Quality Monitoring

The Joint Commission

One Renaissance Boulevard  
Oakbrook Terrace, Illinois 60181

## North Tampa Behavioral Health Notice of Privacy Practices

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

North Tampa Behavioral Health will be referred to in this Notice of Privacy Practices ("Notice") as "Facility". This Notice is given to you by Facility to describe the ways in which Facility may use and disclose your medical information (called "protected health information" or "PHI") and to notify you of your rights with respect to PHI in the possession of Facility. Facility protects the privacy of PHI, which also is protected from disclosure by state and federal law. In certain circumstances, pursuant to this Notice, patient authorization or applicable laws and regulations, PHI can be used by Facility or disclosed to other parties. Below are categories describing these uses and disclosures, along with some examples to help you better understand each category.

### Uses and Disclosures for Treatment, Payment and Health Care Operations

Facility may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you.

**FOR TREATMENT:** Facility may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities at another healthcare facility. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

**FOR PAYMENT:** Facility may use and disclose PHI in order to collect payment for the health care services provided to you. For example, Facility may need to give PHI to your health plan in order to be reimbursed for the services provided to you. Facility may also disclose PHI to their business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. Facility may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

**FOR HEALTH CARE OPERATIONS:** Facility may use and disclose PHI as part of their operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you. Other activities include hospital training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. Facility may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning

**OTHER USES AND DISCLOSURES FOR WHICH AUTHORIZATION IS NOT REQUIRED:** In addition to using or disclosing PHI for treatment, payment and health care operations, Facility may use and disclose PHI without your written authorization under the following circumstances:

**AS REQUIRED BY LAW AND LAW ENFORCEMENT:** Facility may use or disclose PHI when required by law, Facility also may disclose PHI when ordered to in a judicial or administrative proceeding, in response to subpoenas or discovery requests, to identify or locate a suspect, fugitive, material witness, or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, its location or victims, or the identify, description or location of a person who committed a crime, or for other law enforcement purposes.

**FOR PUBLIC HEALTH ACTIVITIES AND PUBLIC HEALTH RISKS:** Facility may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

**FOR HEALTH OVERSIGHT ACTIVITIES:** Facility may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

**CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS:** Facility may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

**ORGAN, EYE, AND TISSUE DONATION:** Facility may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

**RESEARCH:** Under certain circumstances, Facility may use and disclose PHI for medical research purposes.

**TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY:** Facility may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

purposes. These disclosures help make sure that Facility is complying with all applicable laws, and are continuing to provide health care to patients at a high level of quality. Facility may also disclose PHI to other health care facilities plans for certain of their operations, including their quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance, provided that those other facilities and plans have, or have had in the past, a relationship with the patient who is the subject of the information.

**FOR SHARING PHI AMONG FACILITY AND PROFESSIONAL STAFF:** Acadia works together with physicians and other care providers on their professional staff to provide medical services to you when you are a patient at Facility. Facility and members of their respective professional staff will share PHI with each other as needed to perform their treatment, payment and health care operations activities.

**DISASTER RELIEF:** Facility may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**DISCLOSURES TO YOU OR FOR HIPAA COMPLIANCE INVESTIGATIONS:** Facility may disclose your PHI to you or to your personal representative, and are required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. Facility must disclose your PHI to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Uses and Disclosures to Which You May Object:

You may object to the following uses and disclosures of PHI that Facility may make:

**PATIENT DIRECTORIES:** Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts.

Other Uses and Disclosures of PHI for Which Authorization Is Required:

Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which you have the limited right to revoke in writing.

**REGULATORY REQUIREMENTS:** Facility is required by law to maintain the privacy of your PHI, to provide

**LAWSUITS AND DISPUTES:** If you are involved in a lawsuit or a dispute, Facility may disclose health information about you in response to a court or administrative order. **SPECIALIZED GOVERNMENT FUNCTIONS:** Facility may use and disclose PHI of military personnel and veterans under certain circumstances, and may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations.

**WORKERS' COMPENSATION:** Facility may disclose PHI to comply with workers' compensation or other similar laws that provide benefits for work-related injuries or illnesses.

**HEALTH-RELATED BENEFITS AND SERVICES; LIMITED MARKETING ACTIVITIES:** Facility may use and disclose PHI to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you, such as disease management programs.

If you believe that your PHI maintained by Facility contains an error or needs to be updated, you have the right to request that the entity correct or supplement your PHI. Your request must be made in writing to the local Medical Records Department and it must explain why you are requesting an amendment to your PHI. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), Facility will inform you of the extent to which your request has or has not been granted. Facility generally can deny your request if your request relates to PHI: (i) not created by Facility; (ii) that is not part of the records Facility maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, Facility will give you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) submit a request that any future disclosures of the relevant PHI be made with a copy of your request and Facility's denial attached, if you do not file a statement of disagreement; and (iii) complain about the denial.

You generally have the right to request and receive a list of disclosures of your PHI Facility has made during the six (6) years prior to your request (but not before April 14, 2003). The list will not include disclosures (i) for which you have provided a written authorization; (ii) for treatment, payment, and health care operations; (iii) made to you; (iv) for an Facility patient directory or to persons involved in your health care; (v) for national security or intelligence purposes; (vi) to correctional institutions or law enforcement officials; or (vii) of a limited data set. You should submit any such request to the Privacy Officer, and within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), Facility will respond to you regarding the

individuals with notice of their legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. Facility reserves the right to change the terms of this Notice and of its privacy policies, and to make the new terms applicable to all of the PHI it maintains. Before Facility makes an important change to its privacy policies, they will promptly revise this Notice and post a new Notice in registration and admitting areas. You have the following rights regarding your PHI:

You may request the Facility restrict the use and disclosure of your PHI. Facility is not required to agree to any restrictions you request, but if the entity does so it will be bound by the restrictions to which it agrees except in emergency situations.

You have the right to request that communications of PHI to you from Facility be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, or by e-mail rather than regular mail. Your requests must be in writing and sent to the Privacy Officer. Facility will accommodate your reasonable requests without requiring you to provide a reason.

Generally, you have the right to inspect and copy your PHI in the possession of Facility if you make a request in writing to the Facility's Medical Records Department. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), Facility will inform you of the extent to which your request has or has not been granted. In some cases, Facility may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, Facility may impose a reasonable fee to cover copying, postage, and related costs. If Facility denies access to your PHI, it will explain the basis for denial and your opportunity to have the denial reviewed by a licensed health care professional (not involved in the initial denial decision) designated as a reviewing official. If Facility does not maintain the PHI you request, if it knows where that PHI is located it will tell you how to redirect your request.

status of your request. The entity will provide the list to you at no charge, but if you make more than one request in a year you will be charged \$25.00 for each additional request.

You have the right to receive PHI in an electronic format, if electronic medical records are in use in the facility.

You have the right to receive a paper copy of this notice upon request even if you have agreed to receive this notice electronically. You can view a copy of this notice on Acadia's website, [www.acadiahealthcare.com](http://www.acadiahealthcare.com). To obtain a paper copy of this notice, please contact the Privacy Officer.

You have the right to receive notice in the event of a breach of confidentiality

You have the right to opt out of fundraising communications

You have the right to restrict disclosures of PHI to health plans if you have paid for services out of pocket in full.

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of the new notice on our website. The notice will contain the effective date on the second page, in the bottom right-hand corner.

*You may complain to Facility if you believe your privacy rights with respect to your PHI have been violated by contacting Facility's Privacy Officer and submitting a written complaint. To reach the Facility for any reason associated with this Notice, please contact: North Tampa Behavioral Health, Privacy Officer, 29910 SR 56, Wesley Chapel, FL 33543.*

*Facility will not penalize you or retaliate against you for filing a complaint regarding their privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.E., Washington, DC 20201.*

*If you have any questions about this notice, please contact Acadia Healthcare's Compliance Hotline toll-free 866-500-0333, or email to [corporatecompliance@acadiahealthcare.com](mailto:corporatecompliance@acadiahealthcare.com) or write to 830 Crescent Centre Drive, Suite 610, Franklin, TN 37067*

## Rights of Persons

### In Mental Health Facilities and Programs

The following rights are guaranteed to you under Florida law. These will be fully explained to you at the time of and following admission to this facility. A copy of this form will be given to you to keep. You have the right to read the Baker Act law and rules at any time. Your signature on the form, if you choose to sign, only acknowledges that you have had the rights explained and that a copy of this form was provided to you.

#### Individual Dignity

You have the right to individual dignity and access to all constitutional rights. The federal Americans with Disabilities Act (ADA) applies to persons in this facility.

#### Right to Request Discharge by Persons on Voluntary Status

If you request discharge, your doctor will be notified and you will be discharged within 24 hours from a designated community facility and within 3 working days from a state hospital, unless you withdraw your request or you meet the criteria for involuntary placement. If you meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the hospital administrator must file a petition with the Court for your continued stay within two (2) working days of your request for discharge.

#### Designation of Representative

You will be asked to identify a person to be notified in case of an emergency. Further, if you are at this facility for involuntary examination and do not have a guardian appointed by the court, you will be asked to designate a person of your choice to receive notification of your presence in this facility, unless you request that no notification be made. If you do not or cannot designate a representative, a representative will be selected for you by the facility from a prioritized list of persons. You have the right to be consulted about the person selected by the facility and you can request that such a representative be replaced.

#### Communication

You have the right to communicate openly and privately by phone, mail, or visitation with persons of your choice during your stay at this facility. You have the right to make free local calls and will be given access to a long distance service for collect calls. If communication is restricted, you will be given a written notice including the reasons for the restrictions. This facility is required to develop reasonable rules governing visitors, visiting hours, and the use of telephones but you cannot be limited in your access to your attorney, to a phone for the purpose of reporting abuse, in contacting the Florida Local Advocacy Council or the Advocacy Center for Persons with Disabilities. Several toll-free telephone numbers you may wish to keep are:

Florida Abuse Registry	1 800 96-ABUSE or (800) 342-9152
Florida Local Advocacy Council	1 800 342-0825
Advocacy Center for Persons with Disabilities	1 800 342-0823

#### Confidentiality of Information and Records

Information about your stay in this facility is confidential and may not be released, except under special circumstances, without your consent (or the consent of your guardian or guardian advocate or health care surrogate/proxy if you have one). Special circumstances include release of information to your attorney, in response to a court order, to an aftercare treatment provider, or after a threat of harm to another person. You have the right of reasonable access to your clinical record unless such access is determined to be harmful to you by your physician.

#### Treatment

You have the right to receive the least restrictive, available, appropriate treatment in this facility. You will get a physical examination within 24 hours of arrival and you will be asked to help develop a treatment plan to meet your individual needs. The criteria, procedures, and required staff training used by this facility for restraints, seclusion, isolation, emergency treatment orders, close levels of supervision, or physical management are available for your review. Such interventions may never be used for punishment, convenience of staff, or to compensate for inadequate staffing.

#### Advance Directives

You have the right to prepare an advance directive when competent to do so that specifies the mental health care you want or don't want and to designate a health care surrogate to make those decisions for you at the time of crisis. The facility is required to make reasonable efforts to honor those choices or transfer you to another facility that will honor your choices. The facility must document whether you have an advance directive and inform you of its policies about advance directives. There are organizations that can help you prepare an advance directive.

(Continued Over)

## Rights of Persons In Mental Health Facilities and Programs (page 2)

### Informed Consent

Before any treatment is given to you, you will be given information about the proposed treatment, the purpose of the treatment, the common side effects of medication you receive, alternative treatments, the approximate length of care, and that any consent given may be revoked at any time by you, your guardian your guardian advocate, or your health care surrogate/proxy. There are additional disclosures that must be made for medications you receive. If the treatment for which you have given consent is changed at any time during your stay in this facility, it will be fully explained by the staff prior to asking for your written consent to the revised treatment.

### Clothing and Personal Effects

You have the right to keep your clothing and personal effects unless they are removed for safety or medical reasons. If they are taken from you, an inventory of the possessions will be prepared and given to you to sign. The possessions will be immediately returned to you or your representative upon your discharge or transfer from this facility.

### Habeas Corpus

You or your representative has the right to ask the Court to review the cause and legality of your detention in this facility or if you believe you have been unjustly denied a legal right or privilege or an authorized procedure is being abused. A petition form will be given to you by staff upon your request. If you wish to file a habeas corpus petition, you can submit it to a facility staff member, and it will be filed with the court for you by the facility no later than the next court working day.

### Voting

You have the right to register to vote and to cast your vote in any elections unless the court has removed this right from you. Staff will assist you in arranging for registration or voting.

### Discharge

You have the right to seek treatment from the professional or agency of your choice after your discharge from this facility.

\_\_\_\_\_  
Date \_\_\_\_\_ Time \_\_\_\_\_ am pm  
Person's Signature

\_\_\_\_\_  
Date \_\_\_\_\_ Time \_\_\_\_\_ am pm  
Signature, if applicable, of  Guardian  Guardian Advocate  
 Representative  Health Care Surrogate/Proxy

\_\_\_\_\_  
Date \_\_\_\_\_ Time \_\_\_\_\_ am pm  
Witness Signature

This form must be retained in the clinical record as a receipt that the person received notice of his/her rights at the time of admission. A copy must be given to the person and to any authorized decision-maker for persons incompetent or incapacitated by age or disability.

cc: Check when applicable and initial/date/time when copy provided

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		_____ am pm	
<input type="checkbox"/> Guardian		_____ am pm	
<input type="checkbox"/> Guardian Advocate		_____ a m pm	
<input type="checkbox"/> Representative		_____ am pm	
<input type="checkbox"/> Health Care Surrogate/Proxy		_____ am pm	

## Notice of Person's Admission for Involuntary Examination

Name of Guardian or Representative: \_\_\_\_\_

YOU ARE HEREBY NOTIFIED THAT \_\_\_\_\_

Printed Name of Person Admitted for Examination  
(Name of Facility)

Was admitted to: \_\_\_\_\_

Facility Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

( ) \_\_\_\_\_ on \_\_\_\_\_ Date \_\_\_\_\_ for an involuntary examination.

You are notified of this admission because you have been designated as the person's  representative and the person did not object to you being notified or as his or her  guardian. Prompt notice by  telephone or  in person was given to you within 24 hours of the person's arrival at the facility.

You will be informed of his/her legal proceedings, rights and any restriction of these rights, and of the person's discharge or transfer to another facility. You have the legal right to petition the Court on the person's behalf, question the cause and legality of his/her detention in a facility or if you believe the person is being unjustly denied a right or privilege.

Signature of Administrator or Designee \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ am pm

Printed or Typed Name of Administrator or Designee \_\_\_\_\_

Notice to the local Florida Local Advocacy Council must be given for all persons on involuntary status; such notice may not be waived. A person may choose his or her representative. Only if the person is unable to designate a representative, the facility shall select a representative. When the facility selects the representative, the selection shall be made from the following list in the order of listing:

- |                          |                                   |
|--------------------------|-----------------------------------|
| 1. Health Care Surrogate | 5. Person's Adult Next of Kin     |
| 2. Person's Spouse       | 6. Person's Adult Friend          |
| 3. Person's Adult Child  | 7. Florida Local Advocacy Council |
| 4. Person's Parent       |                                   |

The person shall be consulted with regard to the selection of a representative by the receiving or treatment facility and shall have authority to request that any such representative be replaced. The following shall not be appointed as the person's representative: a licensed professional providing services to the person, an employee of a facility providing direct services to the person, an employee of the Department of Children and Families, an individual providing other substantial services to a person in a professional or business capacity, or a creditor of the person.

Distribution: Check when applicable and initial/date/time when copy is provided.

Individual	Date Copy Provided	Method Copy Provided	Time Copy Provided	Initials of Person Providing Copy
<input type="checkbox"/> Guardian			am pm	
<input type="checkbox"/> Representative			am pm	
<input type="checkbox"/> Florida Local Advocacy Council			am pm	
<input type="checkbox"/> Person's clinical record			am pm	

BAKER ACT

## Inventory of Personal Effects

The following person \_\_\_\_\_ has retained these articles in his or her own custody:


The person has, for medical and safety reasons, placed the following articles in the temporary custody of this facility. (Attach additional sheets if necessary)


This is a correct listing of my personal effects and belongings which I hereby place in custody of the facility:

Signature of Person	Date	Time _____ am pm
Signature/Title of Witness to Inventory	Date	Time _____ am pm
Signature/Title of Witness to Inventory	Date	Time _____ am pm

If the person is unable or unwilling to sign the above, the reason(s) are as follows: \_\_\_\_\_

\_\_\_\_\_

Amendment to the above inventory shall be made on a separate Inventory form, signed by the person, and witnessed by two persons.

This inventory must be amended upon the request of the person, guardian, guardian advocate or representative. All effects held by the facility shall be returned to the person immediately upon the person's discharge or transfer from the facility, unless such return would be detrimental to the person. If not returned to the person, the reason must be documented in the clinical record along with the disposition of the personal effects. The inventory form must be filed in the person's clinical record.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initial of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	

**NORTH TAMPA BEHAVIORAL HEALTH  
ORGAN DONATION/ADVANCE DIRECTIVES**

PATIENT IDENTIFICATION STICKER

**Organ Donation:**

Is the patient an Organ, Tissue, or Eye Donor?

Yes \_\_\_\_\_ No \_\_\_\_\_

If not, would the patient like information on becoming a donor?

Yes \_\_\_\_\_ No \_\_\_\_\_

**Advance Directives/Medical Power of Attorney/Mental Health Power of Attorney:**

- Patient has formulated an Advance Directive, but has not brought a copy to this hospital. Staff have requested the document be provided.
- Patient has formulated an Advance Directive and has provided a copy of the following to hospital staff.
- Patient has formulated a Medical Power of Attorney, but has not brought a copy to this hospital. Staff have requested the document be provided.
- Patient has formulated a Medical Power of Attorney and has provided a copy of the following to hospital staff.
- Patient has formulated a Mental Health Power of Attorney, but has not brought a copy to this hospital. Staff have requested the document be provided.
- Patient has formulated a Mental Health Power of Attorney and has provided a copy of the following to hospital staff.

**Living Will and Advance Directives**

- \_\_\_\_\_ Medical Power of Attorney
- \_\_\_\_\_ Mental Health Power of Attorney
- \_\_\_\_\_ Advance Health Care Directive
- \_\_\_\_\_ Do-Not-Resuscitate- **DNR will not be recognized while admitted to this facility. Patient/**

**Legal Representative acknowledges that facility policy is to stabilize and transfer to a medical facility. Patients' already admitted and found to have a DNR will be transferred to a facility that will honor the DRN within 7 days of notification per Florida Statue 765.1105.**

Does the patient wish to formulate Advance Health Care Directive? Yes\* \_\_\_\_\_ No \_\_\_\_\_

\*The patient was provided information on formulating an Advanced Directives.

Does the patient wish to formulate Medical Power of Attorney? Yes\* \_\_\_\_\_ No \_\_\_\_\_

\*The patient was provided information on formulating an Advanced Directives.

Does the patient wish to formulate Mental Health Power of Attorney? Yes\* \_\_\_\_\_ No \_\_\_\_\_

\*The patient was provided information on formulating an Advanced Directives.

Does the patient have a surrogate decision maker? Yes\* \_\_\_\_\_ No \_\_\_\_\_

\*Name \_\_\_\_\_ Contact Number \_\_\_\_\_

Patient/Legal Representative Signature: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**NORTH TAMPA BEHAVIORAL HEALTH  
INTAKE  
INFECTIOUS DISEASE SCREENING FORM**

PATIENT IDENTIFICATION STICKER

Have you traveled outside of the U.S. in the last month?

No  Yes — list: \_\_\_\_\_

If Yes, Intake Coordinator reviews the current CDC Travel Notices.

Contact the Physician/Practitioner if the individual visited any of the known countries of outbreak.

Physician/Practitioner: \_\_\_\_\_

Date Contacted: \_\_\_\_\_

Time Contacted: \_\_\_\_\_

Comments: \_\_\_\_\_

Do you have any of the following signs and symptoms?

- \_\_\_ Persistent cough for 2 weeks
- \_\_\_ Coughing up blood
- \_\_\_ Chest pains
- \_\_\_ Shortness of breath
- \_\_\_ Night sweats
- \_\_\_ Rapid weight loss
- \_\_\_ Severe loss of appetite
- \_\_\_ Running fever
- \_\_\_ Lived with anyone that had confirmed TB
- \_\_\_ Had a positive TB skin test in the past

Date of Last TB Test: \_\_\_\_\_  Unknown

If you have tested positive, list medications taken: \_\_\_\_\_

When was your last chest x-ray? \_\_\_\_\_ Results: \_\_\_\_\_

If **3 or more** of the above are present provide a surgical mask for the person being screened and contact the admitting practitioner to determine if additional screening at a medical facility is indicated. Document the practitioner decision through either order to send to medical facility or to proceed with assessment.

Patient/Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

# NORTH TAMPA BEHAVIORAL HEALTH

## CONDITIONS OF ADMISSION/ADMISSION CONSENT

PATIENT IDENTIFICATION STICKER

\_\_\_\_\_  
Initials

### APPLICATION FOR VOLUNTARY ADMISSION

I request to admit myself as a patient to the Hospital for diagnostic observation, care, treatment, medications, and services (which in this document will be referred as the "Care").

\_\_\_\_\_  
Initials

### CONSENT FOR TREATMENT

I agree to accept the Care for myself as ordered by the Hospital physician or practitioner. I understand that I may refuse certain treatments and agree to discuss the refusal with the attending physician. The Hospital explained, and I consented to, the proposed Care. The Hospital told me of reasonable alternatives to the proposed Care, as well as the risks, benefits, and side effects related to those alternatives, including the risks of refusing any care. The Hospital told me that I have the right to revoke this consent at any time, which could result in my discharge from the Hospital, unless the Hospital has a legal obligation to treat me on an involuntary basis.

\_\_\_\_\_  
Initials

### CONSENT TO TRANSFER FOR TREATMENT

I authorize my attending or covering physician to order my transfer to another healthcare facility for emergency care, medical treatment, acute psychiatric treatment, or medical procedure, as my attending physician deems advisable and necessary during my Care here. I have read and fully understand this consent for transfer and agree that I will not seek to hold the referring physician, the Hospital, or its staff liable as a result of the transfer.

\_\_\_\_\_  
Initials

### ASSIGNMENT OF INSURANCE BENEFITS

I understand that the Hospital files health benefit claims as a courtesy to patients. I authorize my health insurance or health benefit plan(s) ("Health Plan") to pay the Hospital or attending physician directly, up to the maximum of the Hospital's and physician's regular charges for the Care. I understand and agree that I am financially responsible to the Hospital for any charges related to my treatment and not covered by my Health Plan unless otherwise dictated by applicable law. I irrevocably assign and convey to the Hospital all rights, title, and interest in any benefits under the terms of the Health Plan and I promise to remit to the Hospital any payment that I may inadvertently receive from my Health Plan for the Care. I also designate, authorize, and convey to the Hospital to the fullest extent permissible under the law and any applicable Health Plan the right and ability to act on my behalf: (1) in connection with any claim, right, or cause of action, including to bring litigation against my Health Plan, that I may have under the Health Plan (including, but not limited to, naming me as a plaintiff in such an action); and (2) to pursue such claim, right, or cause of action in connection with the Health Plan, including but not limited to, with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act ("ERISA") - as provided in 29 CFR § 2560.5031(b)(4) - in relation to any expense incurred as a result of the Care, and to claim on my behalf any relevant benefits, claims, or reimbursement, and any other applicable remedy, including fines. I expressly and knowingly assign and convey to the Hospital all rights, title, and interest in any and all causes of action I may have under ERISA for breach of fiduciary duty or to recover benefits, as well as any other legal and/or administrative causes of action.

\_\_\_\_\_  
Initials

### RELEASE FOR PATIENT VALUABLES

I understand and agree that the Hospital maintains an area for safekeeping of money and valuables, that I will not hold the Hospital liable for loss or damage to any money, personal valuables or other articles unless I gave those items to the Hospital for safekeeping.

\_\_\_\_\_  
Initials

### RIGHT TO SEARCH

I agree that the Hospital may search my belongings and remove any items that the Hospital believes may be potentially dangerous to me or others.

\_\_\_\_\_  
Initials

### RELEASE FROM RESPONSIBILITY OF ELOPEMENT

If I leave the Hospital without discharge ordered by my attending physician or without knowledge or supervision of the Hospital staff, I release the Hospital from liability for whatever happens to me or my condition as a result of my leaving the Hospital.

\_\_\_\_\_  
Initials

### CONSENT TO PHOTOGRAPH

I permit the Hospital to take photographs of me as identification.

**NORTH TAMPA BEHAVIORAL HEALTH**

**CONDITIONS OF ADMISSION/ADMISSION CONSENT**

PATIENT IDENTIFICATION STICKER

\_\_\_\_\_  
Initials

**SATISFACTION SURVEY**  
The Hospital will give me a Satisfaction Survey around the time of discharge. The Hospital will not publicize my responses to the survey in a way that identifies me as a patient or as the source of the survey results. The Hospital may contact me by telephone or in writing to follow up on that survey, or for any other reason post-discharge.

\_\_\_\_\_  
Initials

**RECEIPT OF NON-DISCRIMINATION NOTICE**  
I have received the Hospital Nondiscrimination policy. The Hospital has explained the policy to me during the admission process in a language that I understand.

\_\_\_\_\_  
Initials

**RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES INFORMATION**  
I have received my Patient Rights and Responsibilities information.

\_\_\_\_\_  
Initials

**RECEIPT OF THE PATIENT GRIEVANCE INFORMATION**  
I have received the Hospital Patient Grievance Information. The Hospital has explained process to me during the admission process in a language that I understand.

\_\_\_\_\_  
Initials

**INTERPRETERS**  
(As applicable) Patients with language, vision, hearing, or speech barriers have a right to special arrangements designed to enhance communication and comfort. The hospital will furnish, at no cost to the patient, interpreters and auxiliary aids. I hereby give my permission for the hospital to use a language interpreter for the purposes of communicating treatment information. I understand the interpreter will have access to my medical/psychiatric information only through the interpretation of this information. I understand the interpreter will NOT have access to my medical records.

\_\_\_\_\_  
Initials

**NO PHYSICIAN AVAILABLE 24/7 NOTIFICATION**  
I understand that a physician is not present 24 hours/day, seven days a week. If an emergency medical condition occurs, a Registered Nurse will assess the situation, provide basic life support, and call the on-call physician and/or EMS-911.

\_\_\_\_\_  
Initials

**HIPAA - CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS:** I understand and have been provided with a Notice of HIPAA Privacy practices and provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance, thereon. I understand by signing below I was given or asked if I wanted a copy of my HIPAA rights.

My initials on the items show that I have read, understood, and agree to them.

<b>Patient:</b>	<b>Legal Representative: (if applicable):</b>	<b>Hospital Staff Member:</b>
_____	_____	_____
Signature	Signature	Signature
_____	_____	_____
Date	Date	Date
_____	_____	_____
Time	Time	Time

**NORTH TAMPA BEHAVIORAL HEALTH  
DESIGNATION OF REPRESENTATIVE/ EMERGENCY CONTACT**

PATIENT IDENTIFICATION STICKER

**Representative/ Emergency Contact:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

I have reviewed this information and have had an opportunity to ask questions.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

2<sup>nd</sup> Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

(2<sup>nd</sup> witness signature required if patient unable or refuses to sign)

## North Tampa Behavioral Health Notice of Privacy Practices

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

North Tampa Behavioral Health will be referred to in this Notice of Privacy Practices ("Notice") as NTBH. This Notice is given to you by an Acadia Facility to describe the ways in which NTBH may use and disclose your medical information (called "protected health information" or "PHI") and to notify you of your rights with respect to PHI in the possession of NTBH. NTBH protects the privacy of PHI, which also is protected from disclosure by state and federal law. In certain circumstances, pursuant to this Notice, patient authorization or applicable laws and regulations, PHI can be used by Acadia or disclosed to other parties. Below are categories describing these uses and disclosures, along with some examples to help you better understand each category.

**Uses and Disclosures for Treatment, Payment and Health Care Operations**  
NTBH may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you.

**FOR TREATMENT:** NTBH may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities at another healthcare facility. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide your health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

**FOR PAYMENT:** NTBH may use and disclose PHI in order to collect payment for the health care services provided to you. For example, NTBH may need to give PHI to your health plan in order to be reimbursed for the services provided to you. NTBH may also disclose PHI to their business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. NTBH may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

**FOR HEALTH CARE OPERATIONS:** NTBH may use and disclose PHI as part of their operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you. Other activities include hospital training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. NTBH may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes. These disclosures help make sure that NTBH is complying with all applicable laws, and are continuing to provide health care to patients at a high level of quality. NTBH may also disclose PHI to other health care facilities plans for certain of their operations, including their quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance, provided that those other facilities and plans have, or have had in the past, a relationship with the patient who is the subject of the information.

**FOR SHARING PHI AMONG OHP AND PROFESSIONAL STAFF:** NTBH works together with physicians and other care providers on their professional staff to provide medical services to you when you are a patient at another facility. NTBH and members of their respective professional staff will share PHI with each other as needed to perform their treatment, payment and health care operations activities.

**OTHER USES AND DISCLOSURES FOR WHICH AUTHORIZATION IS NOT REQUIRED:** In addition to using or disclosing PHI for treatment, payment and health care operations, NTBH may use and disclose PHI without your written authorization under the following circumstances:

**AS REQUIRED BY LAW AND LAW ENFORCEMENT:** NTBH may use or disclose PHI when required by law, NTBH also may disclose PHI when ordered to in a judicial or administrative proceeding, in response to subpoenas or discovery requests, to identify or locate a suspect, fugitive, material witness, or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, its location or victims, or the identify, description or location of a person who committed a crime, or for other law enforcement purposes.

**FOR PUBLIC HEALTH ACTIVITIES AND PUBLIC HEALTH RISKS:** NTBH may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

**FOR HEALTH OVERSIGHT ACTIVITIES:** NTBH may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

**CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS:** NTBH may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

**ORGAN, EYE, AND TISSUE DONATION:** NTBH may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

**RESEARCH:** Under certain circumstances, NTBH may use and disclose PHI for medical research purposes.

**TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY:** NTBH may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

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**SPECIALIZED GOVERNMENT FUNCTIONS:** NTBH may use and disclose PHI of military personnel and veterans under certain circumstances, and may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations.

**WORKERS' COMPENSATION:** NTBH may disclose PHI to comply with workers' compensation or other similar laws that provide benefits for work-related injuries or illnesses.

**HEALTH-RELATED BENEFITS AND SERVICES; LIMITED MARKETING ACTIVITIES:** NTBH may use and disclose PHI to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you, such as disease management programs.

**DISCLOSURES TO YOU OR FOR HIPAA COMPLIANCE INVESTIGATIONS:** NTBH may disclose your PHI to you or to your personal representative, and are required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. NTBH must disclose your PHI to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

**Uses and Disclosures to Which You May Object:**

You may object to the following uses and disclosures of PHI that NTBH may make:

**PATIENT DIRECTORIES:** Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts.

**Other Uses and Disclosures of PHI for Which Authorization is Required:**

Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which you have the limited right to revoke in writing.

**REGULATORY REQUIREMENTS:** NTBH is required by law to maintain the privacy of your PHI, to provide individuals with notice of their legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. NTBH reserves the right to change the terms of this Notice and of its privacy policies, and to make the new terms applicable to all of the PHI it maintains. Before NTBH makes an important change to its privacy policies, they will promptly revise this Notice and post a new Notice in registration and admitting areas. You have the following rights regarding your PHI:

You may request the NTBH restrict the use and disclosure of your PHI. NTBH is not required to agree to any restrictions you request, but if the entity does so it will be bound by the restrictions to which it agrees except in emergency situations.

You have the right to request that communications of PHI to you from NTBH be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, or by e-mail rather than regular mail. Your requests must be in writing and sent to the Privacy Officer. NTBH will accommodate your reasonable requests without requiring you to provide a reason.

Generally, you have the right to inspect and copy your PHI in the possession of NTBH if you make a request in writing to the applicable NTBH's Health Information Management (HIM) Department. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), NTBH will inform you of the extent to which your request has or has not been granted. In some cases, NTBH may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, NTBH may impose a reasonable fee to cover copying, postage, and related costs. If NTBH denies access to your PHI, it will explain the basis for denial and your opportunity to have the denial reviewed by a licensed health care professional (not involved in the initial denial decision) designated as a reviewing official. If NTBH does not maintain the PHI you request, if it knows where that PHI is located it will tell you how to redirect your request.

If you believe that your PHI maintained by NTBH contains an error or needs to be updated, you have the right to request that the entity correct or supplement your PHI. Your request must be made in writing to the HIM department and it must explain why you are requesting an amendment to your PHI. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), NTBH will inform you of the extent to which your request has or has not been granted. NTBH generally can deny your request if your request relates to PHI: (i) not created by NTBH; (ii) that is not part of the records NTBH maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, NTBH will give you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) submit a request that any future disclosures of the relevant PHI be made with a copy of your request and NTBH's denial attached, if you do not file a statement of disagreement; and (iii) complain about the denial.

You generally have the right to request and receive a list of disclosures of your PHI NTBH has made during the six (6) years prior to your request (but not before April 14, 2003). The list will not include disclosures (i) for which you have provided a written authorization; (ii) for treatment, payment, and health care operations; (iii) made to you; (iv) for an NTBH patient directory or to persons involved in your health care; (v) for national security or intelligence purposes; (vi) to correctional institutions or law enforcement officials; or (vii) of a limited data set. You should submit any such request to the Privacy Officer, and within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), NTBH will respond to you regarding the status of your request. The entity will provide the list to you at no charge, but if you make more than one request in a year you will be charged \$25.00 for each additional request.

You have the right to receive a paper copy of this notice upon request even if you have agreed to receive this notice electronically. You can view a copy of this notice on NTBH's website, [www.northtampabehavioralhealth.com](http://www.northtampabehavioralhealth.com). To obtain a paper copy of this notice, please contact the Privacy Officer.

You may complain to NTBH if you believe your privacy rights with respect to your PHI have been violated by contacting NTBH's Privacy Officer and submitting a written complaint. NTBH will not penalize you or retaliate against you for filing a complaint regarding their privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.E., Washington, DC 20201.

If you have any questions about this notice, please contact Acadia Healthcare's Compliance Hotline toll-free at 800-508-0333 or e-mail to [corporatecompliance@acadiahealthcare.com](mailto:corporatecompliance@acadiahealthcare.com) or write to 6100 Tower Circle, Suite 1000, Franklin, TN 37067.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I, \_\_\_\_\_, have received a copy of North Tampa Behavioral Health *Notice of Privacy Practices*.

Signature of Client

Date

# North Tampa Behavioral Health

## Financial Responsibility

### \*\*\*\*\*NOTICE OF LIMITED LIABILITY\*\*\*\*\*

I, ON BEHALF OF MYSELF, ACKNOWLEDGE I HAVE BEEN INFORMED THAT Medical care and treatment that I receive at North Tampa Behavioral Health (all herein "NTBH") may provide by NTBH -employed physicians, physician assistants, nurse practitioners, and other individuals (all herein "Providers") who are employees or agents of NTBH.

I further acknowledge that I may receive medical care and treatment from other independent health care contractors, including, but not limited to, my private practicing physician, radiologists, anesthesiologists, emergency care providers, and pathologists, who are neither the employees nor agents of NTBH. I recognize and agree that NTBH is NOT responsible for the acts or omissions of these independent contractors.

I        hereby assign to NTBH payment from all third party payers\* with whom I have coverage or from who benefits are or may become payable to me, for the charges of hospital and healthcare services I receive for, related to, or connected with my admission or treatment (past, present or future).

I        agree to be personally responsible for payment of any hospital or health care services that are not covered by my third party payers\*, including, but not limited to, non-covered or out of network services, deductibles, coinsurance, and/or co-payments.

I        agree and understand that if NTBH is not covered by my insurance company due to denied coverage I will be financial responsibility for all services rendered.

I        also assign payment of any available insurance benefits to the physician(s) who provide me treatment at NTBH.

**NTBH Financial Practices.** I understand and agree that:

I        NTBH's charges for hospital services are set out in the hospital's price list (the "Charge Master") the relevant portions of which I may examine during regular business hours. NTBH reserves the right to review and change the prices set out in the Charge Master.

I        NTBH's account of my hospital charges is an "open account" that will include all of my hospital charges and all payments, whenever such charges or payments are made, as part of a single transaction giving rise to a single liability and NTBH may prepare bills for amounts up to and including the account's total amount due on a regular basis.

I        The amount of hospital charges that I am obligated to pay may differ from the amounts other patients are obligated to pay based upon each patient's private insurance coverage, Medicare/Medicaid coverage, and/or ability to pay.

I        I may request and will be provided with information about NTBH's charity care programs, for which I may qualify if I meet the relevant income tests and otherwise lack the ability to pay the hospital's charges.

I        As a courtesy, NTBH may bill third parties, including my insurance company, but it is not obligated to do so. Regardless, I agree that, except where prohibited by law, I agree to pay those charges reflected on NTBH's uniform billing instruments (UB-04 or CMS-1500 forms) for services rendered to me at NTBH.

# North Tampa Behavioral Health

**Guarantor Agreement.** I hereby agree to the following:

\_\_\_\_\_ I am responsible for paying the charges of all hospital and health care services Patient receive for, related to, or connected with the Patient's admission or treatment (past, present, or future), and the same are due and payable at the time of discharge or discontinuation of treatment. The charges I agree to pay are those listed in NTBH's Charge Master in effect at the time the services were rendered and reflected on the Hospital's uniform billing instrument (UB-04 form).

\_\_\_\_\_ Unless otherwise precluded by law or by contract if as a courtesy NTBH bills third party payors\*. NTBH may demand payment in full of any balance due at any time.

\_\_\_\_\_ I understand that I will be billed separately by NTBH for services rendered by it (including NTBH -employed Providers) and by any independent contractor who provides services to me (for example, my private practicing physician, anesthesiology, radiology, pathology or laboratory services).

\_\_\_\_\_ Any overdue accounts may be referred to a collection agency or attorney, in which case I agree to pay attorney's fees, court costs, and/or collection agency fees associated with the collection processes.

\_\_\_\_\_ Each of the undersigned agree to NTBH inquiring into his/her credit history in conformity with legitimate business needs and applicable laws, rules, and regulations and further agrees that the hospital may, with or without notice, assign, transfer, convey to any agency or attorney its right title and interest in and to any balance due after the patient's discharge.

\_\_\_\_\_ I authorize NTBH to apply non-insurance payments received that exceed the amount necessary to pay NTBH's charges for this hospitalization to the payment of any unpaid NTBH bill of myself.

*\*Third party payors include, but are not limited to, coverage available from: Medicare, Medicaid, Tri-care, or governmental programs; health, accident, automobile, or other insurance; worker's compensation, HMOs, self-insured employers, and any sponsors who may contribute payment for services.\**

**I, the undersigned, as the patient, or the guardian, spouse, guarantor or agent of the patient, hereby certify that I have read, and fully and completely understand this Financial Responsibility and I have signed this Financial Responsibility knowingly, freely, voluntarily, and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any treatment or services.**

\_\_\_\_\_  
 Patient: Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
 When applicable, Signature of Substitute Decision Maker Date \_\_\_\_\_ Time \_\_\_\_\_

Printed Name of Substitute Decision Maker  Guardian,  Guardian Advocate,  Health Care Surrogate/Proxy,

\_\_\_\_\_  
 Witness Date \_\_\_\_\_ Time \_\_\_\_\_

## North Tampa Behavioral Health

29910 SR 56 Wesley Chapel, FL 3354 813-922-3300

### Un mensaje importante de Medicare

Nombre del paciente:

Número del paciente:

#### Sus derechos como paciente hospitalizado:

- Usted puede recibir los servicios que son cubiertos por Medicare. Estos incluyen los servicios hospitalarios que sean necesarios por razones médicas y los servicios que podría necesitar luego de ser dado de alta, siempre y cuando los servicios sean ordenados por su médico. Usted tiene derecho a enterarse de estos servicios, quién los pagará, y dónde podrá obtenerlos.
- Usted puede participar en toda decisión relativa a su hospitalización.
- Usted puede informar sus preocupaciones relativas a la calidad de la atención que recibe a su QIO en: KEPRO: 1-844-455-8708 La QIO es el revisor independiente que Medicare autoriza para revisar la decisión de darle de alta.
- Usted puede trabajar con el hospital para prepararse para la alta de manera segura y organizar los servicios que podría necesitar luego de salir del hospital. Cuando usted ya no necesita atención hospitalaria como paciente internado, su médico o el personal del hospital le informará de la fecha prevista para su alta.
- Usted puede hablar con su médico u otro personal del hospital si tiene inquietudes sobre su alta.

#### Su derecho de apelar el alta del hospital:

- Usted tiene derecho a una revisión (apelación) médica independiente e inmediata de la decisión de darle de alta. Si usted la hace, no tendrá que pagar por los servicios que recibe durante la apelación (salvo los cargos como copagos y deducibles)
- Si decide apelar, el revisor independiente le pedirá su opinión. El revisor además examinará sus expedientes médicos y/u otra información relevante. Usted no tendrá que preparar nada por escrito, pero tiene derecho a hacerlo si desea.
- Si decide apelar, usted y el revisor recibirán una copia de la explicación detallada indicando los motivos por los cuales la cobertura de la hospitalización no debería continuar. Usted recibirá este aviso detallado solamente después de solicitar la apelación.
- Si la QIO determina que usted no está en condiciones para ser dado de alta, Medicare seguirá cubriendo los servicios hospitalarios.
- Si la QIO está de acuerdo en que los servicios no deberían ser cubiertos más allá de la fecha del alta, ni Medicare ni su plan de salud de Medicare pagará por su hospitalización después del mediodía del día en que la QIO le notifica de su decisión. Si usted pone fin a los servicios antes de dicho momento, evitará la responsabilidad económica.
- Si usted no apela, podría tener que pagar por los servicios que reciba más allá de la fecha del alta.

#### Cómo solicitar una apelación del alta del hospital

- Usted deberá presentar su solicitud a la QIO indicada arriba.
- Deberá hacer su solicitud de apelación lo antes posible, pero en la fecha prevista para el alta y antes de salir del hospital, a más tardar.
- La QIO le notificará de su decisión lo antes posible; por lo general, será un máximo de 1 día después de haber recibido toda la información necesaria.
- Llame a la QIO indicada en la Página 1 para apelar o si tiene preguntas.

Si usted pierde la fecha límite para solicitar la apelación, es posible que tenga otros derechos de apelación:

- Si usted tiene Medicare Original: Llame a la QIO indicada en la Página 1.
- Si tiene un plan de salud de Medicare: Llame a su plan al:

Para más información, llame al 1-800-MEDICARE (1-800-633-4227), o para TTY: 1-877-486-2048. CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en formato alternativo, llame al: 1-800-MEDICARE o envíe un mensaje de correo electrónico: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov)

Firme abajo para indicar que usted ha recibido y entendido este aviso. Se me notificó de mis derechos como paciente hospitalizado y que podré comunicarme con mi QIO para apelar el alta.

Firma del paciente o representante

Fecha/Tiempo

De acuerdo con la Ley para la Reducción de Trámites de 1995, ninguna persona será obligada a responder a una recopilación de información a menos que se exhiba un número de control válido de la OMB. El número de control válido de la OMB para esta recopilación de información es 0938-1019. El tiempo necesario para completar esta recopilación de información es de aproximadamente 15 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios, y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## How Do I Prepare for Discharge?

Discharge from the hospital involves several important steps to make sure you are safe, supported, and prepared for the next stage of care. On average, this process can take 2–3 hours. Please note that some steps must be completed in a certain order and multiple patient discharges may occur on the same day.

### Social Work (average 1–2 hours)

- Ensure social work has been informed of any previous or upcoming appointments (therapist, psychiatrist, case manager, service facilitator, primary care, etc.) that you may already have in place.
- Discuss stepping down to the next level of care (PHP and IOP programs). This is not a replacement for any outpatient therapy or medication management that you may already have in place, but rather the next level of support following a hospital discharge that would be in addition to those current supports.
- Verify with social work that you do not have access to firearms, stockpiled medications, or other means of self-harm — OR make a safe plan with social work to remove access
- Confirm your mode of transportation (e.g., friend/family pickup, arranged ride, or alternative options coordinated with social work)
- Collaborate with social work to create a crisis safety plan
- Complete discharge outcome assessment
- Complete patient experience survey

### Nursing (average 1 hour)

- Review and sign belongings list
- Complete and sign pain management form with nursing
- Complete CSSRS (suicide risk) screener with nursing
- Review discharge care plan and After Visit Summary with nursing
- Review discharge medications and returning meds, if applicable
- Verify your pharmacy information

### How Can You Help Expedite Your Discharge?

- Let your social worker know if you already have established appointments with providers.
- If you have your own transportation, ask your social worker what time you can be discharged and arrange your ride in advance.
- Ensure you have a safe place to go after discharge and share this information with your care team. As a reminder, if you are going to someone else's home, you will need to provide your social worker with a release of information to contact the owner of the residence in order to ensure they are expecting you. Social work will NOT disclose information about your stay unless you give them permission to.

\*These tasks must be completed before discharge, and your involvement helps ensure the process move smoothly.\*

\*Please keep in mind, discharges are scheduled based on pickup times. Multiple patients may be discharged on the same day, so please be patient with the process.\*

## **North Tampa Behavioral Health Rights of Persons in Mental Health Facilities and Programs**

The following rights are guaranteed to you under Florida law. These will be fully explained to you at the time of and following admission to this facility. A copy of this form will be given to you to keep. You have the right to read the Baker Act law and rules at any time. Your signature on the form, if you choose to sign, only acknowledges that you have had the rights explained and that a copy of this form was provided to you.

### **Individual Dignity**

You have the right to individual dignity and access to all constitutional rights. The federal Americans with Disabilities Act (ADA) applies to persons in this facility.

### **Right to Request Discharge by Persons on Voluntary Status**

If you request discharge, your doctor will be notified and you will be discharged within 24 hours from a designated community facility and within 3 working days from a state hospital, unless you withdraw your request or you meet the criteria for involuntary placement. If you meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the hospital administrator must file a petition with the Court for your continued stay within two (2) working days of your request for discharge.

### **Designation of Representative**

You will be asked to identify a person to be notified in case of an emergency. Further, if you are at this facility for involuntary examination and do not have a guardian appointed by the court, you will be asked to designate a person of your choice to receive notification of your presence in this facility, unless you request that no notification be made. If you do not or cannot designate a representative, a representative will be selected for you by the facility from a prioritized list of persons. You have the right to be consulted about the person selected by the facility and you can request that such a representative be replaced.

## **Communication**

You have the right to communicate openly and privately by phone, mail, or visitation with persons of your choice during your stay at this facility. You have the right to make free local calls and will be given access to a long distance service for collect calls. If communication is restricted, you will be given a written notice including the reasons for the restrictions. This facility is required to develop reasonable rules governing visitors, visiting hours, and the use of telephones but you cannot be limited in your access to your attorney, to a phone for the purpose of reporting abuse, in contacting the Florida Local Advocacy Council or the Advocacy Center for Persons with Disabilities. Several toll-free telephone numbers you may wish to keep are:

Florida Abuse Registry	1 800 96-ABUSE or (800) 342-9152
Florida Local Advocacy Council	1 800 342-0825
Advocacy Center for Persons with Disabilities	1 800 342-0823

## **Confidentiality of Information and Records**

Information about your stay in this facility is confidential and may not be released, except under special circumstances, without your consent (or the consent of your guardian or guardian advocate or health care surrogate/proxy if you have one). Special circumstances include release of information to your attorney, in response to a court order, to an aftercare treatment provider, or after a threat of harm to another person. You have the right of reasonable access to your clinical record unless such access is determined to be harmful to you by your physician.

## **Treatment**

You have the right to receive the least restrictive, available, appropriate treatment in this facility. You will get a physical examination within 24 hours of arrival and you will be asked to help develop a treatment plan to meet your individual needs. The criteria, procedures, and required staff training used by this facility for restraints, seclusion, isolation, emergency treatment orders, close levels of supervision, or physical management are available for your review. Such interventions may never be used for punishment, convenience of staff, or to compensate for inadequate staffing.

## **Advance Directives**

You have the right to prepare an advance directive when competent to do so that specifies the mental health care you want or don't want and to designate a health care surrogate to make those decisions for you at the time of crisis. The facility is required to make reasonable efforts to honor those choices or transfer you to another facility that will honor your choices. The facility must document whether you have an advance directive and inform you of



29910 SR 56  
Wesley Chapel, FL 33543  
(813) 922-3300

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## INFORMATION REGARDING MEDICAID COVERAGE WHEN THE COVID EMERGENCY ENDS

If you are currently enrolled in Medicaid, familiarize yourself with your state's eligibility rules, and figure out whether you would be eligible if you were to apply today, with your current circumstances and income.

If the answer is yes, be sure you pay close attention to any requests for additional information from your state's Medicaid office, as they may need that in order to keep your coverage in force.

### What to do if you lose your Medicaid coverage

If you have access to an employer-sponsored health plan, your loss of Medicaid coverage will trigger a special enrollment period that will allow you to enroll in the employer's sponsored health plan. This window is only required to be 30 days.

If you do NOT have access to an employer-sponsored health plan, you can apply for a premium tax credit to offset the coverage in the health insurance marketplace in your state. Depending on your income, you might also qualify for cost-sharing reductions (CSR), which will make your out-of-pocket costs more affordable as long as you select a Silver-level plan. For marketplace insurance payors in your state go to: <https://www.healthcare.gov>

The window to enroll in a marketplace plan will start 60 days before your Medicaid coverage ends and will continue for 60 days after it ends. In order to have seamless coverage, you will need to submit your application **before** your Medicaid ends. Your new marketplace plan cannot have a retroactive date and will not take effect until at least the first of the month after you apply. You will have a gap in coverage if you submit your marketplace application after you lose your Medicaid coverage.

Remember that the opportunity to transition to new coverage, from an employer or thru the marketplace, is time limited. If you miss your special enrollment period, you will have to wait until the next annual open enrollment period to sign up for coverage.



## What happens now that you have been Baker Acted?

You will be assessed for 72 hours. During those 72 hours, two Psychiatrists will determine if you need to stay longer and still meet Baker Act criteria. If you need to stay longer, a petition will be filed with the Courts. Please note: you are not automatically discharged at the 72-hour mark if you still meet Baker Act criteria and a petition is filed with the Courts. The doctors may discharge you at any time they feel you no longer meet criteria. The Baker Act Law mandates that a person cannot be released from our facility without the documented approval of a Psychiatrist

Please note: If you were in a medical hospital for clearance before arriving to our facility, the 72 hours examination period begins when you arrive at the medical hospital and is suspended when a physician documents that you have an emergency medical condition. The 72 hours resumes when it is documented by a Physician that the medical condition has stabilized.

## What is the Baker Act Criteria?

A person can be Baker Acted if there is reason to believe that he or she has a mental illness, and because of his or her mental illness:

1. The person has refused voluntary examination after thorough explanation of the reason for the exam **OR** the person is unable to determine if an exam is necessary; **AND**
  - a. Without care or treatment, the person will likely be unable to care for him or herself **OR**
  - b. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to self or others

## What happens after the petition is filed?

Once the petition is filed with the Court, you will be scheduled to have a Court date within 5 business days (or more depending on time needed). We cannot get you an earlier Court date. Court is held right here in our facility every Thursday at 9am (with the exception of holidays).

The day before your court date, the Public Defender may come to speak with you if we think that you still meet the criteria for a Baker Act. He or she will ask you if you want to go to court and ask the judge to release you, or if you prefer to stay and wait for the doctors to discharge you. It is entirely your decision and there will be no repercussions if you choose to go to court. You do not have to go to court if you don't want to, nor are you required to speak to the Public Defender. These are extra rights that are afforded to you under the Baker Act, and it is entirely your decision if you want to exercise those rights.

## What is a Habeas Corpus?

A Habeas Corpus is a petition that requires us (the facility) to prove the legality of your Baker Act. If you feel that you do not meet Baker Act Criteria and are unjustly being held, you may ask any staff member for a Habeas Corpus to fill out. The Baker Act Coordinator will file it with the court, and a copy of the response will be provided to you when received from the judge.

## What else do I need to know?

- Even though you are being held involuntarily, you still have all of the rights afforded to every other patient. A list of those rights can be found on the wall of every unit.
- If you are a Voluntary patient, Baker Act Laws are still applicable. You can request discharge by filling out a form provided by staff. Within 24 hours of filling out the form, you will be discharged unless you withdraw your request or meet the criteria to be Baker Acted.
- If you have more questions about the Baker Act, let any staff member know that you would like to speak to the Baker Act Coordinator.



## Part I Notice of Right of Person on Voluntary Status To Request Discharge From a Receiving Facility

A person on voluntary status or a relative, friend, or attorney of the person may request discharge either orally or in writing at any time following admission to the facility. If the request for discharge is made by a person other than the person, the discharge may depend on the express and informed consent of the person.

If you request discharge, your doctor will be notified and you will be discharged within 24 hours after your request for discharge unless you withdraw your request or you meet the criteria for involuntary inpatient placement or involuntary outpatient placement. If you meet the criteria for involuntary inpatient or outpatient placement, the facility administrator may file a petition with the court for your continued detention within two (2) court working days and you will be detained without your consent, pending a court hearing.

If you wish to request discharge at any time during your stay at this facility, complete the Application for Discharge on the reverse side of page. No action on your part is required, unless you wish to make arrangements for release.

The procedure for requesting discharge has been explained to me and I have had the opportunity to ask questions and receive answers about my right to request discharge.

Printed Name of Person	Signature of Person	Date	Time	am pm
Printed Name of Guardian of Minor	Signature of Guardian of Minor	Date	Time	am pm
Printed or Typed Name of Witness	Signature of Witness	Date	Time	am pm

cc: Check when applicable and provide date/time/initial when copy provided:

<input type="checkbox"/> Person	Date:	Time:           am pm	Initial:
<input type="checkbox"/> Guardian of Child	Date:	Time:           am pm	Initial:

Parts II and Part III are continued on back

Patient Label

Notice of Right to Petition

Notice of Right to Petition for  
Writ of Habeas Corpus or for Redress of Grievances

To: \_\_\_\_\_

PLEASE BE ADVISED that you may petition the Circuit Court for a Writ of Habeas Corpus to question the cause and legality of your detention. Furthermore, a petition may be filed in the Circuit Court in the county in which you are placed for Redress of Grievances alleging that you are being unjustly denied a right or privilege or that an authorized procedure is being abused.

A Petition for Writ of Habeas Corpus and Redress of Grievances (CF MH Form 3090) may be used for this purpose. A petition must be signed by either you, your relative, friend, guardian, guardian advocate, representative, attorney, or the Department of Children and Families.

Staff of this facility will provide a copy of the Writ form to you immediately upon your request. Staff will assist you in completing this Writ form if you request such help. The Petition for a Writ will be submitted by the staff to the Circuit Court no later than the next working day after you submit the form.

\_\_\_\_\_  
Signature of Administrator or Designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

am pm

This completed form must be given to all persons admitted to a facility and to those individuals listed below as applicable.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Health Care Surrogate/Proxy		am pm	