Dear Families and/or Guardian,

Welcome to Pomegranate Health Systems Acute Care Unit.

Enclosed is the admission packet, this includes:

1) Patient Information (pg. 2)
2) Statement of Financial Responsibility/Assignment of Benefits (pg. 3)
3) Voluntary Admission Form (pg. 4)

4) Consents for Treatment (pgs. 5-7)
5) Pharmacy Agreement (pg. 8)
6) Acknowledgment of Privacy Notice (pg. 9)
7) Authorization to Release Information (pg. 10)
8) Valuables Form (pg. 11)
9) Immunization Information (pg. 12)

Please complete all consents/forms mentioned above. Our apologies for the repetition of some of the information asked, however it is important that it all be filled in.

Some helpful information on a few forms:

Privacy Notice - A "CODE" is used when you call us or when we call you to discuss patient information. This code is also used when wanting to speak with the patient. This is for the patient's privacy and no one will be able to talk with or obtain patient information without it. Please make up a 4 digit number that you will remember. Also don't forget to include yourself when filling out names/numbers of those who can visit/call.

Authorization to Release Information – You only need to fill in the top portion with the patient's name, DOB, and SS#

Valuables – Everything coming with the patient needs listed on this form, even the clothes they are wearing. All meds, electronics, wallets, money, IDs, jewelry must be removed and sent home with parents if possible.

Immunization Form – This form is mainly just informational. We are just asking that you read it and at the bottom check whether or not you will provide Pomegranate Health Systems with a copy of your child's immunization records and sign and date.

Please note: On the bottom of some of these forms a witness signature is needed

If this admission packet is being faxed to you: On page 4, the "Voluntary Admission" form will ask that you have read and understand the patient handbook. This handbook is located on our website: http://SEQUEL-PomegranateHealthSystems.com/Admissions. Or, will fax upon request.

Acute Unit General Visiting Hours:
Monday – Friday 4:00-7:00PM
Saturday – Sunday 2:00-5:00PM
Visitors must be over the age of 18 and have a photo ID available. (1 hour visits.)

Please contact us at 614-223-1650 with any questions or concerns you may have.

Sincerely,
The Acute Unit Staff

Patient Information

Reason for Admission: _____

_____

_____

_____

School: _____ Grade: _____ Grades at School: _____

Concentration Issues: ☐ YES ☐ NO Behavior at School: _____

Patient Lives with: _____

Conflicts at Home (if so, who): _____

Abuse History: _____

Medical Concerns: _____

Past medical history:_____

Prior Hospitalizations (if so, when): _____

Family Mental Health History (if so, who): _____

_____

AOD use (ETOH, Caffeine, Cigarettes, and illegal drugs): _____

_____

Sexually Active: ☐ YES ☐ NO Safe Sex: ☐ YES ☐ NO Last Bowel Movement: _____

FEMALES ONLY: Last Menstrual Period: _____ Pregnancy Concerns: ☐ YES ☐ NO

Immunizations Up to Date: ☐ YES ☐ NO

Allergies: _____

Intake Concerns (appetite, N/V, Eating D/O): _____

Sleep Concerns (falling/staying asleep): _____ Number of hours: _____

Nightmares: ☐ YES ☐ NO Involuntary Urination at Night: ☐ YES ☐ NO

Current Medical Medications: _____

Prescribing Physician: _____ Next Apt (Date/Time) _____

Currently taking **Psychiatric Medication**: ☐ YES ☐ NO

Current **Psychiatric** Medications: _____

Previously tried medications: _____

How long has the patient been taking psychiatric medication? _____

Prescribing Physician: _____ Next Apt (Date/Time): _____

How often does the patient see his/her psychiatrist? _____

Does the patient currently see a **Counselor/Therapist:** ☐ YES ☐ NO

How long has the patient been in counseling? _____

Name/Number: _____ Next Apt (Date/Time): _____

How often does the patient see his/her counselor/therapist? _____

STATEMENT OF FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

Date: _____ ****** PLEASE NOTE – ALL SECTIONS MUST BE COMPLETED. ******

Patient Name: _____ **Date of Birth:** _____ M ☐ F ☐
(REQUIRED)

Social Security #: _____ **County of residence:** _____

Contact Address: _____ **City/State/Zip:** _____

GUARDIAN INFORMATION - This person has custody and/or authority to sign for admission.
CIRCLE ONE: MOTHER / FATHER / OTHER

Name: _____ Date of Birth: _____ M ☐ F ☐
(REQUIRED)

Social Security #: _____ Phone: ( ) _____ *CIRCLE ONE: HOME / CELL*

Mailing Address: _____ City/State/Zip: _____

GUARANTOR INFORMATION - This person is ultimately responsible for payment.
CIRCLE ONE: MOTHER / FATHER / OTHER

Name: _____ Date of Birth: _____ M ☐ F ☐
(REQUIRED)

Social Security #: _____ Phone: ( ) _____ *CIRCLE ONE: HOME / CELL*

Mailing Address: _____ City/State/Zip: _____

INSURANCE INFORMATION

****** ALSO - PLEASE PROVIDE INSURANCE CARD(S) AND DRIVERS LICENSE(S) FOR US TO COPY. ******
PLEASE REMEMBER THAT GUARANTOR IS ULTIMATELY RESPONSIBLE FOR ANY AMOUNTS NOT PAID BY INSURANCE.

PRIMARY INSURANCE COVERAGE:
CIRCLE IF POLICY HOLDER INFO IS SAME AS: GUARDIAN / GUARANTOR

Insurance Co.: _____ Insurance Phone: ( ) _____

ID/Policy #: _____ Group #: _____ Group/Employer Name: _____

Policy Holder Name: _____ Date of Birth: _____ M ☐ F ☐
(REQUIRED)

Social Security #: _____ Phone: ( ) _____ *CIRCLE ONE: HOME / CELL*

Mailing Address: _____ City/State/Zip: _____

SECONDARY INSURANCE COVERAGE (if applicable):
CIRCLE IF POLICY HOLDER INFO IS SAME AS: GUARDIAN / GUARANTOR

Insurance Co.: _____ Insurance Phone: ( ) _____

ID/Policy #: _____ Group #: _____ Group/Employer Name: _____

Policy Holder Name: _____ Date of Birth: _____ M ☐ F ☐
(REQUIRED)

Social Security #: _____ Phone: ( ) _____ *CIRCLE ONE: HOME / CELL*

Mailing Address: _____ City/State/Zip: _____

To the best of my knowledge, all of the above information is true and complete. I understand that I am responsible for payment of all charges for services rendered to me (or my covered dependents) and I agree to pay whatever is not covered/paid by insurance.

GUARANTOR SIGNATURE: _____ **DATE:** _____

Voluntary Admission

I, the Legal Representative of _____, date of birth_____; voluntarily request and accept admission for the above minor to the psychiatric service of Pomegranate Health Systems.

I/We have read and understand the Patient Handbook.

I/We agree to follow the rules and regulations of the Hospital.

I/We consent to the care and treatment which my Doctor and the staff find necessary in my case. I/We reserve the right to ask questions about the patient's treatment plan.

I/We agree to leave the Hospital upon the request of the head of the hospital.

I/We understand that the above minor may not leave the Hospital against the advice or consent of the Doctor without giving a written notice of the minor's intention to do so. The minor's stay in the Hospital may be continued for a period of three (3) court days following the submission of the request for discharge if the Doctor and the head of the Hospital determine such to be necessary. Further hospitalization beyond these court days would require a court hearing at which the legal representative may be present and represented by counsel.

Signature of Legal Representative	Date	Time
Printed Name of Legal Representative	Relationship	
Signature of Witness	Date	Time

Treatment Authorizations and Consents

I, the Legal Representative of _____, date of birth _____ :
hereby grant my permission for the following authorizations and consents;

Please initial on the lines below:

_____ **Consent to Treat**
I hereby authorize personnel of SEQUEL-Pomegranate Health Systems to perform such diagnostic and therapeutic procedures as the physician deems necessary for care of the above minor. I understand that the above minor will not be given treatment against his/her wishes and may discuss refusal with the attending physician.

_____ **Consent for Emergency Medical Treatment**
I hereby authorize SEQUEL-Pomegranate Health Systems to arrange for transfer and emergency treatment, or to perform such procedures necessary for emergency diagnosis and treatment of the above minor. I authorize SEQUEL- Pomegranate Health Systems to release to the receiving facility, medical and psychiatric information which is relevant to the emergency treatment of the above minor.

_____ **Social Work Release of Information**
I voluntarily authorize SEQUEL-Pomegranate Health Systems to contact family members and /or significant other(s) to obtain social history information for the purpose of providing care and arranging for follow up care of the above minor. The consequence of refusal, if any, would be inappropriate follow up care. I understand that I have the right to inspect and copy the information that I authorize to be released.

_____ **Legal Guardian/Parent Verification**
I attest that I am the legal guardian/custodial parent of the patient being admitted and have the authority to make medical treatment decisions with respect to him/her. I agree to provide SEQUEL-Pomegranate Health Systems acceptable documentation, such as divorce decree or guardianship papers of such authority within 3 days.

_____ **Assignment of Benefits and Release of Information**
I authorize SEQUEL-Pomegranate Health Systems and the attending physician to release such information as may be necessary for the completion of the hospital's or the physician's claims for reimbursements to the appropriate health care insurer, agency or third party which may be liable for all or part of the patient's hospital or physician charges.

In consideration of the Hospital's and Physician's services received or to be received for psychiatric or medical services, assign to Pomegranate Health Systems and/or the physician all benefits specified, not to exceed the above hospital and physician charges. I direct the insurers to pay such benefits directly to SEQUEL-Pomegranate Health Systems and/or the physician. I hereby agree to be liable for and pay the hospital any co-payments and/or deductibles as identified through my insurance benefits.

Treatment Authorizations and Consents (continued)

_____ **Medicare/Champus Payment**
I certify that the information I provided if applying for payment under Title XVII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including Champus/Champva claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payment for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ **Verification of Insurance**
I understand that it is my responsibility to provide proof of valid insurance within 24 hours of admission. I further understand that by failing to provide proof of insurance I will be held liable for any and all hospital and physician charges.

_____ **Computer Data**
I understand that the minor's personal information and medical records may be accessible by authorized hospital personnel through computers, and SEQUEL-Pomegranate Health Systems will comply with certain safeguards established by federal, state, and local law as well as hospital policy.

_____ **Personal Property**
It is the policy of SEQUEL-Pomegranate Health Systems to request that patients do not bring items of value (electronic, jewelry, money etc.) into the facility. In the event a patient brings an item of value, will not replace or be held liable for items, brought by patients or visitors, which become lost, stolen or broken.

_____ **Policy on Person and Belongings Check for Prohibited Items**
In order to provide a safe treatment environment for all patients and staff, the Hospital stay may require that patients submit to a check of person and belongings for prohibited items at the time of admission and following passes. This check is for the purpose of preventing items deemed dangerous by the facility from coming on to the units. This check is conducted by trained staff and with an order from the physician. The check requires the patient to change into a hospital gown while all clothing and belongings are checked for prohibited items. My initials signify my understanding of this policy and practice.

_____ **Restraint Free Philosophy**
It is our philosophy and goal to maintain a restraint free therapeutic environment. However, should a patient become a threat to self or others, trained staff will utilize restraint techniques as a last resort and only in emergency situations to provide for the safety of patients, visitors, and staff.

_____ **Consent to Photograph**
I hereby consent for a photograph to be taken by SEQUEL-Pomegranate Health Systems for the express purpose of patient identification. This consent is given freely and voluntarily without any promise, threats, or dues. I understand that this photograph will be destroyed at the time of discharge unless requested by the legal representative.

Treatment Authorizations and Consents (continued)

_____ **Video Surveillance and Monitoring/Phone Recording**
I understand that SEQUEL-Pomegranate Health Systems uses a video surveillance system and phone recording system for the purpose of monitoring safety concerns, proper implementation of Policy and Procedures, quality assurance and to review for training purposes. I understand, that private areas of the facility, (i.e., bedrooms and bathrooms), are not monitored by the surveillance system. I understand that the material recorded will be maintained in a highly confidential manner and will only be reviewed by authorized staff. SPHS will make every effort to obtain consent from all parties involved before releasing video and/or phone conversations to regulatory or law enforcement personnel.

_____ **Social Work and Nursing Students**
I understand that occasionally there might be students on the unit as part of their professional training and give permission for these students to be involved in the provision of care.

_____ **Privacy Policy Acknowledgement**
I have read or have read to me and understand the information contained in the Notice of Privacy Practices. All of the information has been explained to me and I have had all my questions answered at this time. By initialing, I am acknowledging the receipt and understanding of the Notice of Privacy Practices.

I have read all of the above and understand the terms. I certify to the best of my knowledge and belief that all information provided is complete and correct.

Signature of Legal Representative	Date	Time
Printed Name of Legal Representative	Relationship	
Signature of Witness	Date	Time

Choice Pharmacy
Pharmacy Service Agreement and Guaranty

Resident: _____
Facility: **SPHS**
Date of Birth: _____ Social Security Number: _____

This Pharmacy Service Agreement ("Agreement") is made and entered into this date _____ by and between Choice Pharmacy ("Pharmacy") and _____ ("Resident"), and _____ (Responsible Party).

Pharmacy agrees to provide the required pharmacy services to the above named resident, and bill monthly for the products and services rendered. Resident and/or responsible party agrees to allow medications and supplies to be ordered for above named resident by the physician and nursing staff.

Pharmacy has permission to bill the appropriate payer for medications furnished for the above named resident. Pharmacy must receive billing information (Medicaid, private insurance, etc.) upon admission to the facility. Failure to provide third party billing information, releases Pharmacy from complying with the requirements of these programs. Resident/Responsible Party assigns benefits payable directly to Pharmacy and authorizes the pharmacy to exchange information related to claims as necessary. Resident/Responsible party will be liable for all co-payments and other charges not covered by the insurance company. If pharmacy does not participate with your insurance program, the pharmacy will bill the Resident/Responsible Party directly and will assist in the filling of any necessary claim forms.

Resident/Responsible Party agrees to make payment in full upon receipt of Pharmacy's billing statement. A monthly finance charge of 1 ½ % per month (18% per year) will be added to all accounts not paid in full. Resident/Responsible Party agrees to pay all costs and expenses incurred by pharmacy in the enforcement of its rights under this Agreement, including but not limited to, collection fees, attorney fees, court costs and expenses related to collection. Resident/Responsible Party recognizes that a voluntary credit transaction occurs with the pharmacy's dispensing of medications and authorizes the pharmacy, or its agent, to obtain a credit report. Pharmacy may at any time terminate service to the resident for any account with a past due balance unless other arrangements for payment are made to the satisfaction of the Pharmacy.

I guarantee to Pharmacy to pay in full any and all sums due and owing to Pharmacy under this Agreement.

Printed Name of Responsible Party	Signature of Responsible Party	Date
	Relationship to Resident	

Address: _____
(please print)

Home Phone: (____) _____ Work Phone: (____) _____

CODE: ___________________
(4-digit number)

Acknowledgement of Privacy Notice

I, the Legal Representative of ____, date of birth, __________________; have received a copy of SEQUEL-Pomegranate Health Systems' Notice of Privacy Practice which includes: identifying the above minor as a patient in this facility and to disclose his/her location within this facility, to report a general description of the patient's condition to individuals who inquire about the patient, and to identify the patient's religious affiliation to members of the clergy.

______ Yes ______ No ______ Agrees but Refuses/Is Unable to Sign

Describe: ____

Notification of Family and/or Others

I hereby authorize the staff of SPHS to disclose to the following persons information as identified in the table below

Person to be Notified (Name, Phone)	Notice of Admission	Information Relating to My Care as Described Below*	Permitted for Visits or Phone Calls
Name: ____________________ Phone: ____________________	___ Yes ___ No	___ Yes ___ No	___ Visitations Approved ___ Phone Calls Approved
Name: ____________________ Phone: ____________________	___ Yes ___ No	___ Yes ___ No	___ Visitations Approved ___ Phone Calls Approved
Name: ____________________ Phone: ____________________	___ Yes ___ No	___ Yes ___ No	___ Visitations Approved ___ Phone Calls Approved
Name: ____________________ Phone: ____________________	___ Yes ___ No	___ Yes ___ No	___ Visitations Approved ___ Phone Calls Approved
Name: ____________________ Phone: ____________________	___ Yes ___ No	___ Yes ___ No	___ Visitations Approved ___ Phone Calls Approved
Name: ____________________ Phone: ____________________	___ Yes ___ No	___ Yes ___ No	___ Visitations Approved ___ Phone Calls Approved
Name: ____________________ Phone: ____________________	___ Yes ___ No	___ Yes ___ No	___ Visitations Approved ___ Phone Calls Approved

*Information relating to the patient above that may be shared is limited to: mediation information, a summary of diagnosis and prognosis, and a list of services and personnel available for assistance.
***** Notifications will be documented within the progress notes.

SIGNATURE FOR NOTICES/PERMITS

I hereby authorize the use and/or disclosure of the patient listed as indicated above.

Legal Representative	Date

Witness	Date

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES PURSUANT TO HIPAA

Patient Name	Date of Birth	Phone Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.
4. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 7(B).

5. Name and address of Sequel Youth and Family Services facility/program to release this information:

6. Name and address of person(s) or category of person(s) to whom this information will be sent:

7(a). Specific information to be released:

☐ Psychotherapy Notes from (insert date) _____ to (insert date) _____

☐ Entire Record of Psychotherapy Notes

☐

Other: _____

_____

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

8. Reason for release of information:	9. If I do not specify a date or event in this box, this authorization shall expire 24 months from the date of my signature below.
☐ At request of individual ☐ Other:	
10. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient: (If applicable, attach supporting documentation).

I understand that after I sign this Authorization I may receive a copy. I also understand that I may inspect or copy the information to be used or disclosed, as provided for in 45 C.F.R. § 164.524.

Date: _____

_____

_____

Signature of patient or representative authorized by law.

Valuables Record

To be completed upon admission and/or anytime a resident has any other items of value brought into the facility.

Item	Quantity	Brief Description	Location
Drivers License			
Glasses			
Hearing Aid			
Jewelry			
Jewelry			
Medical Equipment			
Medications			
Money (amount)			
Purse/Wallet			
Social Security Card			
Watch			
Retainer/Partial			
Other			
Other			

I agree with the assessment of valuables as stated above. I am aware SEQUEL Pomegranate Health Systems cannot be held responsible or liable for my personal possessions.

Signature of Patient:
Signature of Guardian:
Signature of Witness:
Signature of Person Taking Responsibility for Possessions (if different from guardian):
Date:

Location Codes:
PT-on patient G-with guardian NS-nurses station TH-with therapist HK-with housekeeping

Childhood Immunization Schedule

	Birth	2 months	4 months	6 months	12-15 months	4-6 years	11-18 years
Hep-B Hepatitis B	✓	✓		✓			
DTap/Tdap Diphtheria, Tetanus, Pertussis		✓	✓	✓	✓	✓	✓
Hib Haemophilus Influenza type B		✓	✓	✓	✓		
IPV Polio		✓	✓	✓		✓	
PCV7 Pneumococcal conjugate		✓	✓	✓	✓		
MMR Measles, Mumps, Rubella					✓	✓	
Chickenpox Varicella					✓	✓	
Rota Rotavirus		✓	✓	✓			
Hep-A Hepatitis A					☑		
MCV4 Meningococcal							✓
HPV Human Papilloma virus							☑
Flu Influenza		***Every year beginning at 6 months of age***					

Immunizations and regular doctor check-ups are important to your child's good health

✓ - These check marks show at what ages and what immunizations a child is recommended to receive.

☑ - These check marks indicate these immunizations are a part of a series:

- Hepatitis A is a two dose series spaced 6 months apart and is given to all children at 12 months of age.
- HPV is given as a 3 dose series at 0, 2, 6 month spacing schedule.

Immunizations and regular doctor check-ups are important to your child's good health.

NEED IMMUNIZATIONS ?

Your child's health care provider can give the immunizations your child needs. Make sure that you ask about shots at every visit.

Public health department clinics provide low cost shots as well. Call either the Franklin County Board of Public Health (614-462-3635) or Columbus Public Health (614-645-7945).

I have read and understand the above information.

Parent/Guardian Signature _____ Date _____

Child/Adolescent's Signature _____ Date _____

For the safety of our youth and staff, SEQUEL-Pomegranate Health Systems encourages the parent/guardian to provide the facility with the child/adolescent's immunization record.

☐ I WILL PROVIDE IMMUNIZATION RECORDS ☐ I WILL NOT PROVIDE IMMUNIZATION RECORDS

****IMMUNIZATION RECORDS MAY BE OBTAINED FROM PEDIATRICIAN, PUBLIC HEALTH DEPT. OR SCHOOL SYSTEM****