Moore Resolutions Group, LLC

109 Osigian Blvd. Suite 300B, Warner Robins, GA
4116 Arkwright Rd. Suite 1, Macon, GA 31210
WR Phone: (478) 333-2411
Macon Phone: (478) 216-5534

About Us

Welcome to Moore Resolutions Group, LLC. We are the standard in ethical and individualized psychological assessments, diagnosis, and treatment. Moore Resolutions Group, LLC recognizes that wellness requires not only health of the body, but also, health of the mind, which is why we offer mental and behavioral health counseling, as well as addiction and marital counseling. Our integrative approach provides comprehensive and individualized treatment plans that ensure clients are being provided with accurate diagnosis.

Our Services:

Assessment and Diagnostic Treatment and Care
Children/Adolescent (ADD/ADHD, Anxiety, Autism Spectrum, Conduct Disorder, Defiant, Oppositional)
Adult (Depression, Anxiety, ADD/ADHD, OCD, Mental Illness)
Geriatric (Grief counseling, Behavioral Health, and difficulty adjusting)
Individual and Family Counseling
Substance Abuse Counseling
Premarital/Marriage Counseling and Support
Therapy for Therapist and other Social Service Providers

Insurance Accepted

Tricare
CareSource
Aetna
Cigna
Medicare
Humana
GEHA
Cash/Major Credit Cards
WellCare
Amerigroup
Ambetter
Peachstate
BlueCross BlueShield
Georgia Federal
Cenpatico
United Healthcare

MOORE RESOLUTIONS

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________
Guardian: ______________________ Contact Number(s): ______________

Cancellation/No Show Policies

CANCELLATION POLICY: We look forward to working with you. Our appointment sessions are approximately 45-60 minutes long. It is our strict policy to stay on time for all scheduled appointments. Therefore, if at all necessary, your wait time is kept to a minimum.

Due to the length of time provided for each appointment, it is critical that you arrive on time for your appointments. If you are more than 15 minutes late, we will have no choice but to reschedule your appointment and you will be responsible for the fees of a no show. In order to avoid paying no show fees, we require at least a 24-hour notice for all cancellations, unless your appointment is on Monday, at which cancellation needs to be before 12pm on the prior Friday.

Insurance companies will not pay for "Late Cancellation", therefore you will be responsible for the $25.00 fee for a late cancellation. After 2 late cancellations, you will not be able to reschedule another appointment without consent of the therapist and at that time it will be decided on whether we will discontinue services with you and refer you to another provider.

NO SHOW POLICY: Insurance companies will not pay for "No-Shows"; Therefore, you will be responsible for the $50.00 fee for a No-Show. **For our Medicaid/Medicare patients our No-Show Policy is as follows:** 1st offense – you will receive a verbal warning, which will be noted in your patient file; 2nd offense – you will receive a written warning of the date the verbal warning was given along with the dates of the no-shows, copy will be placed in your patient file as well as mailed to your mailing address on file; 3rd offense – services will terminated, and noted in your patient file.

Please Initial

_______ I understand there is a **24-hr. notice for cancellations**. There is a **$25.00 fee** for late or day-of cancellations. The fee will be waived if appointment is rescheduled within 2 business days. There is a **no-show fee of $50.00**.

_______ I understand other treatment options may need to be discussed after repeated **NO SHOWS/LAST MINUTE CANCELLATIONS**.

_______ I understand, I should **NOT** bring my child for therapy if they have run a fever, had a rash, stomach virus, etc. in the previous 24 hours.

_______ I understand that **payment** is always due at time of service no exceptions.

MOORE RESOLUTIONS

Individual: ____________________ Address: ____________________
Insurance: ____________________ Individual's Date of Birth: ____________________
Guardian: ____________________ Contact Number(s): ____________________

PAYMENT POLICY: You are responsible for and shall pay your copay portion of the therapist's charges for the services at the time the services are provided.

CHECK POLICY: Check payments are to be made out to Moore Resolutions Group, LLC. Please note there is a $35.00 charge for any returned checks.

COURT POLICY: Moore Resolutions Group, LLC and its counselors/therapists will not go to court unless subpoenaed in which case there will be a fee of $150.00 per hour, with a minimum of five hours that is required to be paid in full, one week prior to hearing.

RECORDS POLICY: Moore Resolutions Group, LLC will provide paperwork requested by the patient with the current fees. Fees must be paid prior to receiving the documentation. Patient must give counselor adequate time to prepare documents of at least 10 days prior to receiving records. Schedule follow: Doctor's letters - $50.00, FMLA Paperwork - $50.00, and Social Security Paperwork - $75.00.

I have read and understand all policies mentioned above.

Client Name (Printed) **Client or Parent/Legal Guardian Signature** **Date**

MOORE RESOLUTIONS

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________
Guardian: ______________________ Contact Number(s): ______________

CLIENT INTAKE FORM

Please check appropriate boxes. If asked a question, fill in information on designated space. All words that are bold are required information.

Source of Referral: ☐ Self ☐ Primary Doctor ______________ ☐ Friend ☐ Other ______________

Date of Initial Intake ____________ Revised Date: ______________

Client Identification

Last name ______________________ **First name** ______________ MI ______

Address ______________________________ **Date of birth** __________ **Age** ______

Phone number ______________________________

Send mail? ☐ Yes ☐ No Can we email? ☐ Yes ☐ No email: ______________________

Insurance status

Type of medical insurance (Please check all that apply)

☐ **Private** ☐ **Medicare** ☐ **Medicaid** ☐ **Other public insurance** ☐ **VA** ☐ **None**

Name of insurance company ______________________ **Agent address** ______________________

City ______________ **State** ____ **Zip** ______ **Phone** ______________ **email** ______________

Co-pay amount ($) ______________ **Deductible met** __ **Policy number** ______________

Client's education:

☐ **None** ☐ **Unknown** ☐ **Grades 0-6** ☐ **Grades 7-9** ☐ **Grades 10-12** ☐ **2-year college**

☐ **4 yr. college** ☐ **Postgraduate** ☐ **Professional** ☐ **Technical**

Job title: ______________________ **Second job (if any)** ☐ **Full time** ☐ **Part time**

Company name ______________________ **Address** ______________________ **City** __________ **State** ____
Zip ______ **Phone** ______________

MOORE RESOLUTIONS

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________________
Guardian: ______________________ Contact Number(s): ______________________

Personal Information (check one only)

Sex: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Islander
☐ More than one race

Nationality (country of origin) ______________________

Sexual orientation
☐ Heterosexual ☐ Bisexual ☐ Homosexual ☐ Does not apply, child
☐ Transexual ☐ Unknown/unreported ☐ Questioning

What pronoun do you prefer to be referred by?
☐ He/Him ☐ She/Her

Marital status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Co-habitating
☐ Widowed ☐ Other ☐ Unknown

Are You a United States Veteran?
☐ Yes ☐ No

Housing/family/income information

Housing status:
☐ Lives alone ☐ W/ spouse or partner ☐ W/ spouse & children ☐ W/ dependent children
☐ With non-dependent children ☐ W/ parents or guardian & dependent children ☐ W/ parents or guardian only
☐ W/ other relatives ☐ W/ contributing non-relative roommates ☐ W/ non-contributing, non-relative room mates
☐ Lives in shelter/Homeless in street/Lives in foster care

Contact Information / Social Support

Please check ☐ if contact must be done with
Discretion or prior permission in case of emergency or any eventuality.

Social Support:

Contact name ______________________ Address ______________________ City ____________ State ______ Zip ______

Phone ______________________ email ______________________ Relation to Client: ______________________

Special needs/other information Please check all that apply:

☐ Hearing impaired ☐ Visually impaired ☐ Physically impaired ☐ Wheelchair bound

☐ Developmentally disabled ☐ Recently released from incarceration ☐ Recently incarcerated

☐ Chronically mentally ill ☐ Other need ______________________ ☐ None

MOORE RESOLUTIONS

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________
Guardian: ______________________ Contact Number(s): ______________

INDIVIDUAL MEDICATION LOG

Medication	Dosage	Doctor	Date

Previous Mental Health History

____

____

EMERGENCY MEDICAL INFORMATION

Individual and/or Legal Guardian: ______________________________________
Address______________________________________

Phone (Home)________________ Cell____________________ Work____________________

Emergency Contact Name: ______________________________________

Address ______________________________ Phone______________ Cell______________

Physician or Health Care Center: ______________________________________

Address ______________________________________

Phone: ______________________ Fax:______________________
Any known allergies or health problems? ______________________________________

____

Therapist / Psychiatrist: ______________________________________

Address______________________________________

Phone and Fax ______________________________________
Case Manager and Agency: ______________________ Address______________________________

Phone and Fax ______________________________________

MOORE RESOLUTIONS

Individual: ____________________ Address: ____________________
Insurance: ____________________ Individual's Date of Birth: ____________________
Guardian: ____________________ Contact Number(s): ____________________

AUTHORIZATION FOR **PRIMARY CARE PHYSICIAN or PHYSICAL CLINIC**

I hereby authorize Moore Resolutions Group, LLC to (check all that apply):

□ Exchange with □ Release to □ Obtain from **the parties I have indicated below**

I hereby authorize Moore Resolutions Group, LLC to exchange / release / obtain information:

□ Verbally only □ in written form only □ both verbally and in writing

Person/organization receiving/communicating the information:

Name		Address:	
City	State	Zip	Phone Number: ( ) Extension

I understand my medical record may contain sensitive information about such things as alcohol and drug use, HIV, mental health conditions, sexual and reproductive health, and similar matters.

Photocopies of the following information (including any of my medical records received from another Healthcare Provider except where specifically prohibited)

____ALL DATES ____DATES OF TREATMENT ____ to ____:

General Medical Record:

____Progress notes

____Other: ____

____Psychological Evaluation

____Other: ____

Mental Health:

____Immunization Record

____Educational Evaluation

For the purpose of: ____________________

I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that I may cancel this authorization at any time by signing the cancellation notice at the bottom of this page and giving it to the Moore Resolutions Group, LLC staff. I also understand that this authorization will automatically expire one year from the date of my signature. This consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer; and the date, event or condition upon which the consent will expire if not revoked before. This data, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

____________________ ____________________

Signature of Patient or Person authorized to act on behalf of the patient Date Signed

If patient is unable to authorize release of information or is a minor, state basis for authority to release information:

_______a) Health care power of attorney, guardianship, court order, letter of administration (attach copy)

_______b) Relative or person authorized by law (State relationship or authority)

____________________ ____________________

Witness Date Signed

CANCELLATION: Sign only if you are canceling this authorization. Sign: ____________________

I hereby cancel this authorization for release of medical records effective this date: ____________________

MOORE RESOLUTIONS

RESOLVING CONFLICTS WITHIN

Individual: ____________________ Address: ____________________
Insurance: ____________________ Individual's Date of Birth: ____________________
Guardian: ____________________ Contact Number(s): ____________________

AUTHORIZATION FOR **Mental Health Service Provider**

I hereby authorize Moore Resolutions Group, LLC to (check all that apply):

□ Exchange with □ Release to □ Obtain from **the parties I have indicated below**

I hereby authorize Moore Resolutions Group, LLC to exchange / release / obtain information:

□ Verbally only □ in written form only □ both verbally and in writing

Person/organization receiving/communicating the information:

Name		Address:	
City	State	Zip	Phone Number: ( ) Extension

I understand my medical record may contain sensitive information about such things as alcohol and drug use, HIV, mental health conditions, sexual and reproductive health, and similar matters.

Photocopies of the following information (including any of my medical records received from another Healthcare Provider except where specifically prohibited)

_____ALL DATES __________DATES OF TREATMENT ___________to_____________:

General Medical Record:
____Progress notes
____Other: __________________

____ Diagnosis
____Psychological Evaluation
____Other:________________

Mental Health:
____Other
____Educational Evaluation

For the purpose of:____

I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

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I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

____ ______________________
Signature of Patient or Person authorized to act on behalf of the patient Date Signed

If patient is unable to authorize release of information or is a minor, state basis for authority to release information:

_______a) Health care power of attorney, guardianship, court order, letter of administration (attach copy)
_______b) Relative or person authorized by law (State relationship or authority)

____ ______________________
Witness Date Signed

CANCELLATION: Sign only if you are canceling this authorization. Sign: ______________________________

I hereby cancel this authorization for release of medical records effective this date: ____________________

MOORE RESOLUTIONS

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________
Guardian: ______________________ Contact Number(s): ______________

AUTHORIZATION FOR **GENERAL RELEASE OF INFORMATION**

I hereby authorize Moore Resolutions Group, LLC to (check all that apply):

□ Exchange with □ Release to □ Obtain from **the parties I have indicated below**

I hereby authorize Moore Resolutions Group, LLC to exchange / release / obtain information:

□ Verbally only □ in written form only □ both verbally and in writing

Person/organization receiving/communicating the information:

Name		Address:	
City	State	Zip	Phone Number: ( ) Extension

I understand my medical record may contain sensitive information about such things as alcohol and drug use, HIV, mental health conditions, sexual and reproductive health, and similar matters.

Photocopies of the following information (including any of my medical records received from another Healthcare Provider except where specifically prohibited)

____ALL DATES ________DATES OF TREATMENT __________to___________:

General Medical Record:
___Progress notes
___IEP
___Other: ______________

___Report Card
___Psychological Evaluation
___Other: ______________

Mental Health:
___Immunization Record
___Educational Evaluation

For the purpose of:____

I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that I may cancel this authorization at any time by signing the cancellation notice at the bottom of this page and giving it to the Moore Resolutions Group, LLC staff. I also understand that this authorization will automatically expire one year from the date of my signature. This consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer; and the date, event or condition upon which the consent will expire if not revoked before. This data, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

____ ______________________
Signature of Patient or Person authorized to act on behalf of the patient Date Signed

If patient is unable to authorize release of information or is a minor, state basis for authority to release information:

_______a) Health care power of attorney, guardianship, court order, letter of administration (attach copy)
_______b) Relative or person authorized by law (State relationship or authority)

____ ______________________
Witness Date Signed

CANCELLATION: Sign only if you are canceling this authorization. Sign: ______________________

I hereby cancel this authorization for release of medical records effective this date: ______________

MOORE RESOLUTIONS

Individual: ___________________________ Address: ______________________________
Insurance: ___________________________ Individual's Date of Birth: _________________
Guardian: ____________________________ Contact Number(s): ____________________

AUTHORIZATION FOR RELEASE from **SCHOOL**

I hereby authorize Moore Resolutions Group, LLC to (check all that apply):
□ Exchange with □ Release to □ Obtain from **the parties I have indicated below**

I hereby authorize Moore Resolutions Group, LLC to exchange / release / obtain information:
□ Verbally only □ in written form only □ both verbally and in writing

Person/organization receiving/communicating the information:

Name		Address:	
City	State	Zip	Phone Number: ( ) Extension

I understand my medical record may contain sensitive information about such things as alcohol and drug use, HIV, mental health conditions, sexual and reproductive health, and similar matters.

Photocopies of the following information (including any of my medical records received from another Healthcare Provider except where specifically prohibited)

____ALL DATES ____________DATES OF TREATMENT ____________to______________:

General Medical Record:
____Progress notes
____IEP
____Other: ________________

____Report Card
____Psychological Evaluation
____Other: ________________

Mental Health:
____Immunization Record
____Educational Evaluation

For the purpose of:____

I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that I may cancel this authorization at any time by signing the cancellation notice at the bottom of this page and giving it to the Moore Resolutions Group, LLC staff. I also understand that this authorization will automatically expire one year from the date of my signature. This consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer; and the date, event or condition upon which the consent will expire if not revoked before. This data, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

____ ___________________________
Signature of Patient or Person authorized to act on behalf of the patient Date Signed

If patient is unable to authorize release of information or is a minor, state basis for authority to release information:

_______a) Health care power of attorney, guardianship, court order, letter of administration (attach copy)
_______b) Relative or person authorized by law (State relationship or authority)

____ ___________________________
Witness Date Signed

CANCELLATION: Sign only if you are canceling this authorization. Sign: ______________________________

I hereby cancel this authorization for release of medical records effective this date: ____________________

Individual: ____________ Address: ____________
Insurance: ____________ Individual's Date of Birth: ____________
Guardian: ____________ Contact Number(s): ____________

Informed Consent Form

Permission for Treatment:

I consent to receive mental health services from Moore Resolutions Group, LLC. These services may include individual counseling, couple counseling, as well as family and group counseling. Moore Resolutions Group, LLC is a training agency, and at times there may be an associate licensed or mental health interns working towards licensure, working with a therapist; at any time, you may elect not to have an intern present during your therapy sessions. The number and length of sessions needed depends on many factors and will be discussed by the therapist. You may withdraw from therapy at any time, but please be courteous and discuss this with your therapist.

Emergency Services:

Moore Resolutions Group, LLC is able to provide counseling services by appointment during the work week, Monday through Friday from 9am to 7pm. Appointments are made through calling the front desk at (478) 333 - 2411. If an appointment is needed immediately due to an emergency, clients are advised to call 911 or use the following list of referrals:

1. Houston Medical Center: Emergency Room, 1601 Watson Blvd. Warner Robins, GA 31093; 478-922-4281
2. Coliseum Northside Hospital: Emergency Room; 400 Charter Blvd, Macon, GA 31210; (478) 757-8200
3. The Medical Center, Navicent Health; 777 Hemlock St. Macon, GA 31210; 478-663-1000

Confidentiality:

Counseling is confidential. Information shared with a counselor will not be disclosed to anyone outside of Moore Resolutions Group, LLC without your written permission except when:

1. There is reasonable suspicion of abuse to a child, elderly person, or vulnerable adult.
2. The client presents as a serious danger to himself/herself or others.
3. The case file is court ordered by a judge.

Signature: I have read and agree to the above statements:

Name Printed: ____________________ Date: ____________

Name Signed: ____________________
(Parent/Guardian signs for persons under 18 years of age.)

Therapist Signature: ____________________ Date: ____________

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________
Guardian: ______________________ Contact Number(s): ______________

Grievance Process

All clients will have the right to file a grievance regarding services and receive an expedient response with the right to appeal the conclusion.

Goal:

To provide a standard, formal, unbiased, and effective procedure by which client or legal guardians can have grievances addressed during service or following discharge.

Procedure:

1. At the time of assessment, the clinician shall assure that the Individual is informed about the policy and procedure regarding grievance resolution.
2. At the time of assessment, the clinician shall assure that the Individual receives written information, as part of the admission package regarding grievance resolution.
3. Individuals whose concerns cannot be resolved informally will be provided with an opportunity to complete an Individual Grievance form or to write a letter to Moore Resolutions Group, LLC.
4. Within 4 working days after a complaint has been formally registered, program director / designee shall assure that the client receives both and oral and written response with a copy provided to the CEO.
5. All completed grievance forms / letters and responses shall be maintained by Monique Moore Designee in a file titled Individual Grievances.
6. If the Individual is not satisfied with the response to his/her grievance, he/she may initiate an appeal directly to the CEO who will designate an impartial committee to investigate.
7. If the Individual is not satisfied with the conclusion of the appeal, he/she will be provided referral information related to Agency, Advocacy Groups, Licensing Specialist, etc.

Signature: I understand and agree to the above statements:

______________________________ Date: ______________
(Parent/Guardian signs for persons under 18 years of age.)

______________________________ Date: ______________
Therapist signature

Individual: ______________________
Insurance: ______________________
Guardian: ______________________

Address: ______________________
Individual's Date of Birth: ______________
Contact Number(s): ______________

Notice of Privacy Practices

Copies of medical records are permitted upon patient request.

Patient rights over their medical information include patient-provider medical records confidentially, permitting Patient access to their medical files, and allowing patients to add or alter their medical records according to those Procedures established by the provider.

Moore Resolutions Group, LLC may disclose medical records about a patient without authorization when seeking payment for health care services, in emergency situations, to the provider's legal counsel, coordinating benefit payments, or to a unit of state or local government for purposes of investigation. Health care providers must disclose medical records in situations pertaining to criminal investigation, or to an appropriate organ, tissue or eye recovery agency.

Health care providers may only disclose medical records upon receipt of patient notifications. Health care providers are prohibited from disclosing any patient identifiable information to a person for educational or research purposes, evaluation and management, or accreditation of a facility unless an acknowledgement not to re-disclose is received.

Moore Resolutions Group, LLC may confirm or deny the presence of an individual to a parent, guardian, next of kin, or any individual who has significant interest in the individual's status. State or local government agencies may report the status of an individual in cases of missing persons where a report has filed.

Moore Resolutions Group, LLC may release information without consent in circumstances of investigations or treatment in case of suspected abuse or neglect of a child or adult and in the licensure/certification of discipline of a health professional.

I, (print name) ______________________________ am the client or parent/guardian and have received an explanation of *The Notice of Privacy Practices* for specific information regarding the handling of PHI.

Signature: I understand and agree to the above statements:

____
(Parent/Guardian signs for persons under 18 years of age.)

____
Date

____
Therapist signature

____
Date

MOORE RESOLUTIONS

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________
Guardian: ______________________ Contact Number(s): ______________

Individual's RIGHTS AND RESPONSIBILITIES

1. The individual has the right to make informed decisions regarding his/her care and participate in decisions regarding care, including the development and revisions of the plan of treatment.

2. The individual shall receive information necessary to make decisions regarding his/her care and is expected to work with Clinician/Paraprofessional toward setting treatment plan and goals.

3. The Moore Resolutions Group, LLC staff member shall communicate in a language or form the consumer can reasonably be expected to understand.

4. Whenever possible, the company shall provide special needs consumers with the assistance necessary to obtain special devices, interpreters, or other aids to facilitate communication. Attention is also paid to literacy level and accommodations will be made to assist as needed.

5. The services of Moore Resolutions Group, LLC will be provided at a time that is mutually determined by staff and consumer.
6. It is the expectation of Moore Resolutions Group, LLC that the consumer makes every effort to keep scheduled appointments. Any blatantly offensive, threatening, or violent behavior could result in termination of services.

7. The individual is informed of any responsibilities he/she may have in the treatment process. The responsibilities of the consumer will be determined by the Clinician's assessment of the problem and goals that are mutually determined for treatment.

8. The individual shall be provided information concerning the assessment of the family problem that relates to the care to be provided by Moore Resolutions Group, LLC.

9. The individual may refuse all or part of his/her treatment to the extent permitted by the law and shall be informed of the expected consequences of such action.

10. The individual does not participate in research.

11. The individual shall be informed at the beginning of the services of charges and policy concerning payment for services (note: individuals referred to services with a child with Medicaid there will be no charge to family). When a consumer is referred to another organization, the individual is informed of any financial benefit to the referring organization.

12. The consumer shall receive care appropriate to his/her needs in a timely manner. There shall be continuity in the care provided by Moore Resolutions Group, LLC. The individual shall be informed in a timely manner of the need to transfer to another organization and/or level of care and of pending discharge continuing care requirements, and other available services if needed.

13. The individual shall be admitted to company services only if Moore Resolutions Group, LLC can provide needed care at the level of intensity required by the individual's condition. The individual shall be referred to alternate services, if available, when Moore Resolutions Group, LLC is unable to meet individual needs.

14. All information concerning individual treatment shall be treated confidentially within the confines of Georgia law. As required by law, Moore Resolutions Group, LLC staff members are mandated reporters and are required to report situations in which an individual is a danger to themselves or others. Information will not be released to any organizations/individuals (outside of the referring agency) without the written consent of the individual.

MOORE RESOLUTIONS

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________
Guardian: ______________________ Contact Number(s): ______________

Individual's RIGHTS AND RESPONSIBILITIES CONTINUED

15. The individual shall be informed upon admission of the Moore Resolutions Group, LLC mechanism for receiving, reviewing and resolving individual complaints. A Individual Concern Form can be requested through the Moore Resolutions Group, LLC staff member or by contacting: Moore Resolutions Group, LLC 4100 Riverside Drive suite 97 Macon, GA 31210, 478-333-2411.

16. The individual shall be given the opportunity to voice grievances and recommend changes in policies and services without coercion, discrimination, reprisal or unreasonable interruption of services. Investigation and resolution of alleged infringement of rights will be investigated within a time frame of one week.

17. The individual has the right to insert a statement, in their own words, into their case record. If Moore Resolutions Group, LLC personnel insert a statement in response the individual has the right to review such a response. Individual can also request an in-house review of their treatment and plan.

18. All individuals are free to express their own spiritual beliefs. While receiving services, consideration of spiritual beliefs and practices is given, and efforts made to accommodate individuals in this area.

19. Moore Resolutions Group, LLC staff adheres to HIPAA Privacy and Security Standards regarding disclosure of individual information and access to case records.

20. Moore Resolutions Group, LLC does not discriminate against people seeking services on the basis of race, spiritual belief, gender identity, ethnicity, socio-economic status, age, sexual orientation or disability. Moore Resolutions Group, LLC ensures that the person served is protected from physical, sexual, psychological, and fiduciary abuse (exploitation of the persons served for financial gain); harassment and physical punishments; and humiliating, threatening, or exploiting actions.

21. The person served will be provided information in regard to legal entities for appropriate representation, when needed. The person will be provided information in regard to self-help and advocacy support services, when needed.

______________________________ ______________________
Individual Signature Date

______________________________ ______________________
Parent/Legal Guardian (if applicable) Date

______________________________ ______________________
Therapist Signature/Title Date

MOORE RESOLUTIONS

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________
Guardian: ______________________ Contact Number(s): ______________

PATIENT POLICY AND FINANCIAL RESPONSIBILITY AGREEMENT

Authorization to Release Information:

By signing below, I hereby authorize Moore Resolutions Group, LLC to release information to insurance carriers concerning my illness and treatment.

Authorization to Pay:

By signing below, I hereby assign Moore Resolutions Group, LLC any outstanding payments due for mental and behavioral health treatment rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance company.

Acceptance of Financial Responsibility:

All professional services rendered are the responsibility of the patient regardless of insurance coverage and whether there is an accident with another person at fault. Insurance is filed as a courtesy to you, but you are ultimately responsible for your balances. My signature below indicates I have read and understand all of the financial responsibilities that may arise during my course of treatment at Moore Resolutions Group, LLC.

Notice of Privacy Practice:

I acknowledge by signing below that I understand I can ask for and receive or retrieve from the company website a copy of Moore Resolutions Group, LLC Notice of Privacy Practices and Notice of Individual Rights.

I hereby agree that in addition to intending to follow the policies and procedures listed above, I have provided true and accurate information to the best of my ability. I also agree that if I have questions about any of these policies, I will address them before signing with a Moore Resolutions Group, LLC staff member who will then note concern on the back of this form.

Patient's Name (or Responsible Party):______________________________ Patient's DOB:__________

Patient's Signature (or Responsible Party): ______________________________ Date: ______________

Individual: ______________________ Address: ______________________
Insurance: ______________________ Individual's Date of Birth: ______________
Guardian: ______________________ Contact Number(s): ______________

E-mail Consent Form

I, ____________________, grant consent for my mental health care provider, ___________________________, to correspond with me via e-mail for the purpose of scheduling appointments, or conveying general information about my treatment or the treatment of my child. **I understand that e-mail is not a secure form of communication and that confidentiality of any e-mailed information cannot be ensured.**

☐ By checking the box to the left, I am indicating a preference that the text of any e-mail be delivered as an attached, password-protected Word Document, using the following password (choose a combination of ***at least nine letters and numbers***):

"___________________________". I understand that only the text within the Word document will remain confidential. The confidentiality of the e-mail message itself cannot be assured.

☐ By checking the box to the left, I am granting consent for my mental health care provider to communicate with me via e-mail that is ***not*** password protected. I understand that because e-mail is not a secure form of communication, confidentiality cannot be ensured of any information sent via e-mail.

Please be advised that e-mail is not to be used to communicate urgent matters or emergencies. This is not a consent to release information to any specific person other than the client (or the client's parent/guardian when the client is under age 18).

Please indicate your e-mail address: ____

______________________________ ______________________________
Signature of Client Witness

______________________________ ______________________________
Date Date