SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Nursing staff in ER/outpatient clinic- please make sure all witness signatures are signed with date/times where identified. Please make a copy of the guardian's photo ID and the child's insurance card. Please fax back the signed paperwork to 912-638-6897. Please have all originals travel with the child to our facility.

Dear Parent/Legal Guardian,

Completing the attached documents:

- Only the Legal Guardian can sign this packet.
- The minor patient cannot sign the consents.
- You must sign all areas that are marked with an "x" beside them.
- Please provide your current nurse with your photo ID and your child's insurance card to copy for our records.
- Witness signatures must be completed by a family member who is present or by your current nurse.
- If you have questions about any of the forms please have your nurse contact us to discuss with you.
- We do request legal documentation if you are not the biological parent or if you have any legal involvement regarding parental choices/custody. We will need this documentation faxed to our Intake Department within 24 hours of your child's arrival. Please fax to 912-638-6897.

What to expect:

- Please reference the contraband list in this packet to pack accordingly. Please send your child's items with them from their current location or you can bring and drop them off with our front desk.
- You will not be able to come to the facility at time of admission. Therefore, when your child leaves the hospital you will not be able to ride with EMS or follow them over.
- When your child arrives to the facility he/she will be assessed by our Intake Department.
- Once the assessment is completed your child will then be admitted to their unit.
- A member of the Intake Department will call you shortly after his/her admission to provide you with a passcode.
    - Passcode- you will use this number when you call the hospital to reach the unit your child is on. The passcode will also allow you access to your child's providers in the hospital. If for any reason you do not receive a call please contact the Intake Department at 912-638-1999.
- Typically you can expect your child to be in our care for an average of 3-7 days. However, this will always depend on your child and his/her response to treatment.
- Your child's therapist will reach out to you throughout his/her stay because you are a very important part of treatment.
- At this current time we are NOT doing in-person visitations. We only complete phone visitations until further notice.

Tarah Tracy, LPC
Director of Admissions
St. Simons By-the-Sea Hospital
2927 Demere Rd. St. Simons Island, GA 31522

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Patient Identification Label

Registration Information

X TODAY'S DATE / TIME:

Thank you for choosing Saint Simons By-The-Sea. Our Admissions staff will meet with you for a no-cost clinical assessment, and to discuss your needs and treatment alternatives. In order to assist you and your family in identifying available resources, please complete the following information.

PATIENT INFORMATION

NAME, (FIRST, MIDDLE, LAST)				SSN
ADDRESS				HOME PHONE (with area code)
CITY	STATE	ZIP CODE	COUNTY	CELL PHONE (with area code)
MARITAL STATUS	DATE OF BIRTH	AGE	GENDER	OCCUPATION
PREFERRED LANGUAGE (for discussing healthcare)	RACE	ETHNICITY	ORGAN DONOR (check one) □ Yes | □ No	

EMAIL ADDRESS:	**MILITARY** (Currently or previously enlisted): □ No □ Yes IF yes, dates of service and branch: _____

GUARDIAN/SPOUSE	HOME PHONE (with area code)	WORK PHONE (with area code)	CELL PHONE (with area code)

EMERGENCY CONTACT	RELATIONSHIP	HOME PHONE (with area code)	WORK PHONE (with area code)
ADDRESS	CITY, STATE		ZIP CODE

REFERRING AGENCY: How did you know to call St. Simons By-the-Sea?

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	SUBSCRIBER NAME	POLICY NUMBER
INSURED DATE OF BIRTH	SUBSCRIBER SOCIAL SECURITY NUMBER	INSURANCE CO. PHONE (with area code)
INSURED EMPLOYER	EMPLOYER ADDRESS	CITY/STATE

IF THE PATIENT HAS AN ADDITIONAL/SECONDARY INSURANCE PROVIDER, PLEASE COMPLETE THE REQUESTED INFORMATION BELOW

SECONDARY INSURANCE (if applicable)	SUBSCRIBER NAME	POLICY NUMBER
INSURED DATE OF BIRTH	SUBSCRIBER SOCIAL SECURITY NUMBER	INSURANCE CO. PHONE (with area code)
INSURED EMPLOYER	EMPLOYER ADDRESS	CITY/STATE

I give the Admissions staff member(s) at Saint Simons By-The-Sea permission to perform a clinical assessment, and to verify my insurance benefits and eligibility.

This consent is subject to revocation at any time, except to the extent that action has been taken. This consent will expire after the action is completed.

X **Signature of Patient/Legal Guardian:** _____

ADMISSION

SAINT SIMONS
BY-THE-SEA
A TRADITION OF EXCELLENCE

Patient Identification

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT'S RIGHTS/NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges that a copy of the patient rights and Notice of Privacy Practices has been given to him/her, that these rights and practices have been explained, and that he/she understands them. The undersigned acknowledges that a copy of the **NOTICE OF RIGHTS TO HEARING (Form 1015)** has been given to him/her, that these rights have been explained, and that he/she understands these rights.

RESPONSIBILITY FOR DESTRUCTION OF PROPERTY

The undersigned understands that patients are responsible for any damage to or destruction of SSBTS property, or property belonging to others that may be located at SSBTS. The undersigned agrees to accept liability for, and to reimburse SSBTS or other owners of property that the patient may damage or destroy.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered to SSBTS, to the extent permitted by law, I (1) hereby irrevocably assign, transfer and set over to SSBTS (2) all of my rights, title, and interest to medical reimbursement, including but not limited to, (3) the right to designate a beneficiary, add dependent eligibility and (4) to have an individual policy continued or issued in accordance with the terms of benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by SSBTS during the pendency of the claim for this admission. Such irrevocable assignment and transfer shall be for the recovery on said policies of insurance, but shall not be construed to be obligation of SSBTS to pursue any such right of recovery. The undersigned hereby authorized insurance companies or payer(s) to pay directly to SSBTS all benefits due for services rendered.

DISCHARGE POLICY INFORMATION

The undersigned understands that it is the policy of SSBTS to attempt to provide a structured therapy regime with effective quality treatment. If the treatment regime in not completed prior to the exhaustion of the patient's health insurance benefits, the undersigned agrees to be liable for any charges incurred which are not paid by insurance in addition to the deductible and/or co-payment liability. It is not SSBTS policy to discharge or transfer patients or end treatment regimes simply because insurance benefits have been exhausted.

ADVANCE DIRECTIVE / HEALTHCARE PROXY ACKNOWLEDGEMENT

The undersigned acknowledges the following:

- I have been give written material about my rights to accept or refuse medical treatment.
- I have been informed of my rights to formulate Advance Directives
- I understand that I am not required to have an Advance Directive in order to receive medical treatment at SSBTS
- I understand that the terms of any Advance Directive that I have executed will be followed by St. Simons By-the-Sea, and my care givers to the extent permitted by law.
- I understand that St. Simons By-the-Sea does not honor Advance Medical Directives for "Do Not Resuscitate" requests, and will perform basic life support (CPR) on any medically unstable patient until said patient can be transferred to a medical facility.
- The undersigned will complete the Advance Directive Acknowledgment for Behavioral Health and Medical care form, specifically identifying the patient's status regarding the Advance Directive, a Healthcare Proxy, a Surrogate Decision-Maker, and/or a Legal Guardian/Representative.
- The Advance Directive Acknowledgment form will also allow the patient to identify whether he/she is an organ donor, and desires for organ donation.

NOTE: PARENT OR GUARDIAN MUST SIGN BELOW IF THE PERSON FOR WHOM HOSPITALIZATION IS SOUGHT IS A MINOR OR HAS BEEN DECLARED LEGALLY INCOMPETENT AND THE APPLICATION IS BEING MADE BY THE LEGAL GUARDIAN.

As the parent or legal guardian of the below-named person, I agree to the provisions of this application and I consent to the treatment of the person named below. I have had the opportunity to ask any questions.

SIGNATURE OF PATIENT X	SIGNATURE OF INSURED/ GUARANTOR X	DATE
SIGNATURE OF LEGAL GUARDIAN X	SSBTS STAFF MEMBER'S NAME	DATE TIME

ADMISSION

INT 410 / August 2016

White Copy – Chart Copy Yellow Copy – Business Office Pink Copy – Patient Copy

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Patient Label

PATIENT MEDICAL HISTORY/MEDICATIONS

ALLERGIES: _____

PRIMARY CARE PHYSICIAN: _____ **LAST APPOINTMENT DATE:** _____

SIGNIFICANT FINDINGS OR CURRENT TREATMENT(S) FOR MEDICAL ISSUES: _____

_____

PLEASE INDICATE IF PATIENT HAS HAD PREVIOUS OR CURRENT TREATMENT FOR:			
PREGNANCY ❑N/A	YES: ❑	NO: ❑	IF YES, DESCRIBE:
DIABETES	YES: ❑	NO: ❑	IF YES, IS PATIENT INSULIN DEPENDENT: **YES ❑ | NO ❑**
RESPIRATORY ISSUES Asthma, COPD, Emphysema, Shortness of breath, etc.	YES: ❑	NO: ❑	IF YES, DESCRIBE:
CARDIAC ISSUES Hypertension, CHF, Heart Attack (MI), Chest pain, Pacemaker, etc.	YES: ❑	NO: ❑	IF YES, DESCRIBE:
ISSUES WITH SKIN INTEGRITY Catheters, IV/ PICC Lines, Stiches/Sutures, Open wounds, Draining wounds, et	YES: ❑	NO: ❑	IF YES, DESCRIBE:
RENAL/ URINARY ISSUES UTI, Kidney Stones, Dialysis, Incontinence, etc	YES: ❑	NO: ❑	IF YES, DESCRIBE: IF YES FOR INCONTINENCE: BLADDER ❑ | BOWEL ❑
NEUROLOGICAL ISSUES CVA (Stroke), Seizures, TBI, etc.	YES: ❑	NO: ❑	IF YES, DESCRIBE:
MUSCULOSKELETAL ISSUES Broken bones, Cerebral Palsy, Inability to walk, Scoliosis, Fractures, etc.	YES: ❑	NO: ❑	IF YES, DESCRIBE: ANY RECENT FALLS? **YES ❑ | NO ❑**
HEPATIC (LIVER) ISSUES Cirrhosis, Hepatitis, etc.	YES: ❑	NO: ❑	IF YES, DESCRIBE:
PAIN (1 = NO PAIN | 10 = SEVERE PAIN)	YES: ❑	NO: ❑	IF YES → **CHRONIC ❑ | ACUTE ❑** **LOCATION(S):** **SEVERITY (1-10):**

PLEASE INDICATE AN HISTORY OF:			PLEASE INDICATE ANY CURRENT SYMPTOMS:		
Measles, Mumps, or Rubella	YES: ❑	NO: ❑	Chills or Body Aches	YES: ❑	NO: ❑
Tuberculosis	YES: ❑	NO: ❑	Persistent Fever	YES: ❑	NO: ❑
C. Difficile or E. Coli	YES: ❑	NO: ❑	Vomiting or Diarrhea	YES: ❑	NO: ❑
MRSA or VRE	YES: ❑	NO: ❑	Productive Cough	YES: ❑	NO: ❑
Lice, Scabies, Bedbugs	YES: ❑	NO: ❑	Night Sweats	YES: ❑	NO: ❑
Last Tetanus shot:	Date: _____		Incontinence	YES: ❑	NO: ❑
If yes to any above, please describe:			Please describe any medical symptoms not previously listed:		

PLEASE CONTINUE TO BACK OF PAGE

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Patient Label

PLEASE LIST ANY RECENT OR PREVIOUS SURGERIES

PLEASE LIST ANY CURRENT MEDICATIONS

❑ No Home Medications

MEDICATION NAME	DOSE	FREQUENCY	COMPLIANT		PRESCRIBER
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	
			YES: ❑	NO: ❑	

FOR ADMISSIONS STAFF USE ONLY:

❑ (5 PTS) TB HISTORY OR ON TB MEDS
❑ (3 PTS) RECENT TB EXPOSURE
❑ (3 PTS) COUGH > 2 WEEKS
❑ (3 PTS) BLOODY SPUTUM
❑ (2 PTS) JAILED IN PAST TWO YEARS
❑ (2 PTS) IMMUNOCOMPROMISED (HIV, CANCER)
❑ (2 PTS) FEVER, CHILLS, OR NIGHT SWEATS
❑ (2 PTS) UNEXPLAINE DWEIGHT LOSS >30 LBS IN PAST 30 DAYS
❑ (1 PT) FOREIGN BORN
❑ (1 PT) RECENT TRAVEL OUTSIDE OF U.S.A.
❑ (1 PT) HOMELESS OR LIVING IN A SHELTER

TOTAL POINTS: _____ **| IF PATIENT HAS RECEIVED FIVE OR MORE POINTS,** WHILE IN THE HOSPITAL, SYMPTOMATIC PATIENTS SHOULD WEAR A SURGICAL/PROCEDURES MASK, IF POSSIBLE, AND SHOULD BE INSTRUCTED TO OBSERVE STRICT RESPIRATORY HYGIENE AND COUGH ETIGUETTE PROCEDURES. STAFF SHOULD CONTACT A PHYSICAN/ NURSE FOR DIRECTION ON CARE AND POSSIBLE REFERRAL TO AN ACUTE CARE FACILITY FOR A COMPLETE MEDICAL EVALUATION.

_____ _____ _____
PATIENT SIGNATURE/LEGAL GUARDIAN SIGNATURE DATE TIME

_____ _____ _____
ADMISSION STAFF SIGNATURE DATE TIME

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Patient Identification

Current Outpatient Psychiatrist

RELEASE OF INFORMATION
Saint Simons By-the-Sea Hospital
2927 Demere Road Phone: (912) 638-1999
Saint Simons Island, GA 31522 Fax: (912) 634-9890

I authorize Saint Simons By-the-Sea

To [ ] release to:
To [ ] obtain from:

Name of Person/Facility/Entity

Complete Mailing Address

Phone Number Fax Number

The requested information to be released shall consist of duplicated records concerning the treatment and/or education on or about: _____

The specific information being requested consists of:

[ ] Discharge Summary [ ] Diagnosis [ ] Continuing Care/Discharge Plan
[ ] Psychiatric Evaluation [ ] Medication Information [ ] Laboratory Data/EKGs
[ ] Medical History [ ] Other_____ [ ] Verbal notification of assessment and/or admission and to collect info.

This information is to be used for the purpose of:

[ ] Follow-Up/Continuity of Care [ ] Personal Files [ ] Treatment at Saint Simons By-the-Sea
[ ] Residential Placement [ ] Other

X This authorization contains restrictions [ ] YES [ ] NO If yes, please list: _____

This authorization may be revoked at any time by the patient. The revoking of this authorization shall not cancel any prior action that has already transpired. Specification of date, event, or condition upon which this consent expires is:

If left blank, this consent expires 180 days after discharge, unless this is an insurance request at which time it will expire after insurance benefits have been paid.

I have read and understand the nature of the authorization. I understand that I may revoke it at any time. I release the hospital, its directors, physicians and employees and the above named organization from any and all liability that may arise from this action whether or not foreseen at present. I understand that certain medical records, including any alcohol*, drug abuse information* and HIV, may be protected by Federal Laws and Regulations - *42 U.S.C. 290-3 and 42 U.S.C. 290ee-3 for Federal Law and 42 CFR Part 2 for Federal regulations - but may be included.

The individual for whom this authorization is applies has the right to examine and obtain a copy of the information to be disclosed.

Signature of Patient X Date Time

X Signature of Parent/Guardian X Date X Time

X Witness X Date X Time Witness Date Time

VERBAL APPROVAL REQUIRES 2 WITNESSES!

LEGAL / CONSENTS

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Patient Identification

Current Outpatient Therapist

RELEASE OF INFORMATION
Saint Simons By-the-Sea Hospital
2927 Demere Road Phone: (912) 638-1999
Saint Simons Island, GA 31522 Fax: (912) 634-9890

I authorize Saint Simons By-the-Sea

To [ ] release to:
To [ ] obtain from:

_____
Name of Person/Facility/Entity

_____
Complete Mailing Address

_____ _____
Phone Number Fax Number

The requested information to be released shall consist of duplicated records concerning the treatment and/or education on or about: _____

The specific information being requested consists of:

[ ] Discharge Summary [ ] Diagnosis [ ] Continuing Care/Discharge Plan
[ ] Psychiatric Evaluation [ ] Medication Information [ ] Laboratory Data/EKGs
[ ] Medical History [ ] Other_____ [ ] Verbal notification of assessment and/or admission and to collect info.

This information is to be used for the purpose of:

[ ] Follow-Up/Continuity of Care [ ] Personal Files [ ] Treatment at Saint Simons By-the-Sea
[ ] Residential Placement [ ] Other

_____

X This authorization contains restrictions [ ] YES [ ] NO If yes, please list: _____

_____

This authorization may be revoked at any time by the patient. The revoking of this authorization shall not cancel any prior action that has already transpired. Specification of date, event, or condition upon which this consent expires is:

_____

If left blank, this consent expires 180 days after discharge, unless this is an insurance request at which time it will expire after insurance benefits have been paid.

I have read and understand the nature of the authorization. I understand that I may revoke it at any time. I release the hospital, its directors, physicians and employees and the above named organization from any and all liability that may arise from this action whether or not foreseen at present. I understand that certain medical records, including any alcohol*, drug abuse information* and HIV, may be protected by Federal Laws and Regulations - *42 U.S.C. 290-3 and 42 U.S.C. 290ee-3 for Federal Law and 42 CFR Part 2 for Federal regulations - but may be included.

The individual for whom this authorization is applies has the right to examine and obtain a copy of the information to be disclosed.

_____ \ _____ _____
Signature of Patient Date Time

X _____ X _____ X _____
Signature of Parent/Guardian Date Time

X _____ X X _____ _____
Witness Date Time Witness Date Time

VERBAL APPROVAL REQUIRES 2 WITNESSES!

LEGAL / CONSENTS

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Patient Identification Label

Continuity of Care Planning

Psychiatrist (Prescribing Medications) ☐ **No Established Provider** ☐ **ROI created by_____(initials)**

NAME				PHONE
ADDRESS				FAX
CITY	STATE	ZIP CODE	COUNTY	Last Appointment
Preferred Appointment: Day of the week: ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ Other_____				Time: ☐ Morning ☐ Afternoon ☐ Other_____

Therapist (Completing Therapy) ☐ **No Established Provider** ☐ **ROI created by_____(initials)**

NAME				PHONE
ADDRESS				FAX
CITY	STATE	ZIP CODE	COUNTY	Last Appointment
Preferred Appointment: Day of the week: ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ Other_____				Time: ☐ Morning ☐ Afternoon ☐ Other_____

Primary Care Physician ☐ **No Established Provider** ☐ **ROI created by_____(initials)**

NAME				PHONE
ADDRESS				FAX
CITY	STATE	ZIP CODE	COUNTY	Last Appointment
Preferred Appointment: Day of the week: ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ Other_____				Time: ☐ Morning ☐ Afternoon ☐ Other_____

Pharmacy ☐ **No Established Pharmacy** ☐ **ROI created by_____(initials)**

NAME			PHONE
ADDRESS			FAX
CITY	STATE	ZIP CODE	COUNTY

SAINT SIMONS BY THE SEA

INSURANCE COVERAGE INFORMATION

Patient's Name: _____ Date of Birth: _____

Primary Insurance Company: _____ ID#: _____

Subscriber's Name: ☐ SAME AS ABOVE _____

Subscriber's Date of Birth: ☐ SAME AS ABOVE _____

Subscriber's SSN: _____

ADDITIONAL INSURANCE INFORMATION

☐ No other insurance

Insurance Company: _____

Policy#: _____ Phone#: _____

Insurance Company: _____

Policy#: _____ Phone#: _____

Insurance Company: _____

Policy#: _____ Phone#: _____

Our facility is required to obtain authorization for the services provided; therefore failure to disclose secondary insurance coverage could result in a denial of payment. Any balances incurred for this reason will be the responsibility of the guarantor.

Signature: _____ Date: _____ Time: _____

Print Name: _____

Witness Signature: _____ Print Name: _____

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do hereby appoint, **Saint Simon's by the Sea** (herein after "my Authorized Representative") to act on my behalf in pursuing a benefit claim or to file an appeal. My authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of a claim, any requested for documents relating to the claim, any appeal of adverse determination of authorization, and any request for external review of an appeal.

I understand that in the absence of the contrary direction from me, I authorize **Saint Simon's by the Sea** To direct all information and notices regarding the claim or appeal to which I otherwise am entitled, including benefit determination, and appeal determination, to my authorized representative only.

I am aware that Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services (the Privacy Standards") govern access to medical information. I understand that in connection with the performance of his/her duties hereunder, my Authorized Representative may receive my Protected Health information, as defined in the Privacy Standards, relating to the claim or appeal. I hereby consent to any disclosure of Protected Health Information to my authorized representative.

Date/Time: _____

_____
(Signature of Patient or Guarantor of Patient)

Acknowledgement
For Business office only

I, St Simons-By-The-Sea have read the above Designation of Authorized Representative and I hereby accept this designation and agree to act as Authorized Representative for _____.

Notice may be sent to the authorized representative at the following address:

Name: Saint Simons By-the-Sea

Street Address: 2927 Demere Rd.

City, State, Zip: St Simons, GA 31522

Phone/Fax Number: 912-638-1999/912-638-6897

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

TELEMEDICINE PATIENT CONSENT/REFUSAL FORM

X PATIENT NAME: _____

X DATE OF BIRTH: _____ GEORGIA MEDICAID ID#: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s)
   assessment / follow-ups
2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)
3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telemedicine consultation.
5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.
7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

Sign only one area

I agree to participate in a telemedicine consultations for the procedure(s) described above.
Signature: _____

If signed by someone other than the patient, indicate relationship: _____

I refuse to participate in a telemedicine consultation for the procedure(s) described above.
Signature: _____

If signed by someone other than the patient, indicate relationship: _____

X DATE: _____ X TIME: _____

X WITNESS: _____

X DATE: _____ X TIME: _____

SAINT SIMONS
BY-THE-SEA
A TRADITION OF EXCELLENCE

Patient Identification

RECEIPT OF NOTICE OF PRIVACY PRACTICES

- ☐ Over 18-years-of-age
- ☒ Under 18-years-of-age
- ☐ Emancipated minor child
- ☐ Over 18, but still dependent

ACKNOWLEDGEMENT

I acknowledge that I have received the Hospital's Notice of Privacy Practices:

_____ _____ _____
Patient's Signature Date Time

_____ _____ _____
X Patient's authorized representatives signature X Date X Time

_____
X Relationship to patient

_____ _____ _____
X Witness Signature X Date X Time

Patient is unable to sign this receipt because_____

_____

Patient has requested no exceptions to the use or disclosure of Protected Health Information at this time.

~~Admissions Staff: Attach original to patients' chart~~

ADMISSION

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Patient Identification

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by St. Simons By-The-Sea are protected by federal law and regulations.

St. Simons By-The-Sea may not acknowledge to any person not involved in the addictive disease program that a specific patient is in treatment, or disclose any information identifying a patient as an alcohol or drug abuser UNLESS:

1. **The patient consents in writing;**
2. **The disclosure is allowed by a court order; or**
3. **The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluations.**

Violation of the federal law and regulations by St. Simons By-The-Sea is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at St. Simons By-The-Sea or against any person who works for St. Simons By-The-Sea, or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

It is important to understand that Federal Law 42 CFR Part 2, and Federal Regulations 42 USC290DD-3, and 42 USC290EE-3, are applicable to you if you are involved in the addictive disease program at St. Simons By-The-Sea. Our program provides alcohol and drug abuse diagnoses, treatment, or referral for treatment which directly or indirectly is federally assisted. This law does not apply to the Veteran's Administration or Armed Forces.

X **Patient Signature:** (LG) _____ X **Date:** _____ X **Time:** _____

Witness Signature: _____ **Date:** _____ **Time:** _____

Rev: 02/09

Saint Simons By-The-Sea 2927 Demere Road St. Simons Island, GA 31522 NOTICE OF RIGHT TO HEARINGS	PATIENT IDENTIFICATION

X Date_____

To:_____ _____

X Patient — Second Representative

_____ _____

First Representative — Guardian Ad Litem (if applicable)

The above-named person has been admitted to this Emergency Receiving/Evaluation Facility under emergency conditions on _____ ___20____.

At this time he/she has certain rights. One of the rights is that either the patient or his/her representative may file for a Writ of Habeas Corpus, if it is believed the patient is being held illegally. This can take place in ONE of two courts of the county where the facility is located.

(1) in the Probate Court if the patient is 17 years or older,

(2) in Juvenile Court if the patient is under seventeen (17)

(3) in the Superior Court of the County (the patient's age does not matter).

A patient or his representative may file a petition in the Probate or Juvenile Court for a protective order if they believe the consumer is not being given a right or a privilege that he/she is supposed to have under the Georgia laws which allow him/her to be in this facility. A petition may also be filed if it is thought a procedure of those laws is being abused. When such a petition is filed the court has the authority to look into the matter and issue any order needed to correct the situation. This petition may be filed with the Probate Court of either the county where the consumer is located or in the county of the patient's home if the consumer is 17years or older. If the patient is under 17 years old, the petition may be filed with the Juvenile Court either of the county where the consumer is found or in the county of the patient's home.

The patient has the right to an attorney when he/she files for a Writ of Habeas Court or when he/she asks the court for protective order. If the patient cannot pay for an attorney, he/she may ask the court to appoint one. If there are any questions, the patient may ask the unit staff and the representative may call.

I have received this form and have had a chance to ask questions, as needed.

_____ _____ _____ _____

X Signature of Patient — X Date/Time — Signature of Witness — Date/Time

COPIES SENT TO

	DATE OF NOTICE OR MAILING	SIGNATURE OF STAFF
Cc: Consumer	_____	_____
First Representative	_____	_____
Second Representative	_____	_____
Guardian At Litem (is applicable)	_____	_____
Clinical Record	_____	_____
Unable to obtain	Signature_____	

Form 1015 (6/92) by authority of O.C.G.A. 37-3-44 & 37-7-44

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Patient Identification

PET THERAPY PROGRAM CONSENT FORM
Patient Agreement to Participate

PLEASE READ THIS CAREFULLY. YOU WILL BE ASKED TO SIGN IT.

Benefits: I am voluntarily choosing to participate in a Pet Therapy Program being sponsored by St. Simons By-the-Sea.

I understand that this type of program has been instituted in other patient-care settings and that studies have shown that pets can have a beneficial effect on health and well-being: providing companionship, love, as well as increased physical activity and emotional responsiveness.

Risks: I am aware and have been informed of the fact that live, domestic animals will be provided by volunteers to be used in the Pet Therapy Program. I understand that the behavior and reactions of the animals are not entirely predictable, and therefore, the animal providers cannot guarantee that the animal will behave properly or that the animal will not bite, claw, scratch, or otherwise inflict injury. I also am aware of no allergy, skin or respiratory sensitivity, or other medical condition(s) that I have which might make touching, handling or being in close proximity to dogs, cats or other domestic animals used in the program potentially harmful to my health.

Agreement: I have been assured that the volunteers providing the animals have carefully selected them, and that the animals to be used have never shown any vicious tendencies heretofore. I have been assured that the activities in the Pet Therapy Program will be supervised at all times by staff and volunteers of St. Simons By-the-Sea. I agree to handle the animals gently. I will try to avoid provoking an angry response from the animal. I understand that I would be provided, within the capability of St. Simons By-the-Sea, medical assistance for any physical injury that may result from my participation in this program. I agree to assume the risk of any injury or illness resulting from my participation, and agree to hold St. Simons By-the-Sea and the staff harmless for the actions of the animals used in the program.

Photographs: I understand that the taking of a photograph is optional and will be used only for the purpose described, and will not be otherwise released without my express permission. The photograph will not be retained in the patient's medical records.

X _____ _____
Patient Signature X Date/Time

X _____ _____
Substitute Decision Maker Signature X Date/Time
(If patient/minor is unable to sign)

_____ _____
Staff Member Signature Date/Time

LEGAL / CONSENTS

INT 420 / March 2022

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

Patient Identification

Philosophy and Practice for Seclusion & Restraint Use

X ___(Initials) **What is the philosophy of the facility regarding Seclusion & Restraint use?** St. Simons By-The-Sea promotes the use of non-physical interventions and seclusion/restraints is used as the last resort to support the safety of the patient and/or others. The facility is committed to prevent, reduce and eliminate the use of seclusion / restraint through early identifications of high-risk behaviors or events. The dignity and privacy of patients will be preserved to the greatest extent during the implementation and monitoring of these interventions.

X ___(Initials) **What is seclusion and restraint and When are they used?** Seclusion is any involuntary confinement of a patient alone in a room or area where he/she is physically prevented from leaving or the perception is given to the patient that he/she is unable to leave the room.

Restraint is a device, hold or medication that involuntarily restricts a patient's freedom of movement, activity or normal access to one's body.

Seclusion or restraints are used when it has been determined that it will be the least restrictive intervention that will be effective to provide immediate physical safety of the patient, a staff member, or others and it is discontinued at the earliest possible time. They require a physician's order and are never used as a form of discipline, punishment or convenience for the staff.

X ___(Initials) **What alternatives are tried before using seclusion or restraint?**

Staff use a variety of alternatives to try and avoid the use of seclusion/restraint. These options may include:

- Giving the patient clear instructions and directions about his/her behavior.
- Encouraging the patient to talk about what's making him/her angry and/or frustrated.
- Reducing negative stimuli in the patient's environment e.g. loud noises, turning out lights, allowing the patient alone time.
- Offering diversionary and physical activities e.g. TV, music, exercise, reading.
- Providing medications that the physician has ordered to help the patient to relax/gain control of his/her emotions.
- Using information provided by the patient and/or family regarding what calms him/her.

X ___(Initials) **What behaviors Will result in release from restraint?** Patients are released from restraints when they demonstrate behavioral control, show improved ability to understand and follow directions and are no longer dangerous to themselves, other patients and/or staff.

X ___(Initials) **How can you help?** If you are aware of events in the past that you think may trigger these behaviors, or if you are aware of methods that have been used in the past that were helpful, please inform the staff. To the extent that it is possible, we will incorporate this information into the treatment plan.

(Must select one below)

☐ **If a seclusion/restraint intervention is used during your hospital stay, who would you want to be notified?**

select one

X Name: _____ X Phone #: _____

☐ **I do not want anyone to be notified.**

X ___(Initials) The parent/guardian will be notified when seclusion/restraint is used and the reason for this intervention in all cases with minors (patient younger than 18 years of age). Further, any physical altercations the patient is involved in while in our care the legal guardian will also be updated.

X **Patient Signature** _____ X **Date/Time** _____

X **Parent/Guardian Signature** _____ X **Date/Time** _____

Staff Signature _____ **Date/Time** _____

ADMISSION

ENSURING HOME SAFETY

RECOMMENDATIONS FOR FAMILIES

If you are concerned that a member of your household may be suicidal, there are steps you should take to restrict access to dangerous weapons, lethal medications and other harmful substances at home.

IMPORTANT NUMBERS

SAINT SIMONS BY THE SEA
912-638-1999

GEORGIA ACCESS TO CARE, Free for GA residents, 24/7 800-715-4225

NATIONAL SUICIDE PREVENTION LIFELINE 1-800-273-TALK (8255)
www.suicidepreventionlifeline.org

TREVOR LIFELINE, LGBT crisis
866-4-U-TREVOR

VETERANS CRISIS LINE 800-273-8255
POISON CONTROL: 800-222-1222

IN CASE OF ANY TYPE OF EMERGENCY, PLEASE CALL 911

COMMON MEANS OF SUICIDE

Fire Arms	Electrocution & Drowning	Hanging & Strangulation
Firearms are the most lethal among suicide methods, so it is very important that you remove them or, at the very least, lock up and secure them until things improve at home.	Monitor bathroom/pool use of persons who are suicidal to ensure they do not try to drown themselves. Remove any plugged in electrical devices that can be pulled into a pool or bathtub.	Belts, shoelaces, strings, ropes and other objects can easily be used for hanging. Decrease the risk of suicide by hanging or strangulation by removing or locking up all hazardous items if possible.
Sharp Objects	**Alcohol**	**Gas & Carbon Monoxide Poisoning**
Lock up sharp objects such as knives and razor blades and objects that can be broken into sharp pieces, such as glass and metal, whenever possible	Alcohol increases the chance that a person will make an unwise choice, like attempting suicide, and heightens the lethality of a drug overdose. Keep only small quantities of alcohol at home.	Exposure to car exhaust fumes or emissions from gas appliances, in enclosed "non-ventilated" areas, can be fatal. CO is a colorless, odorless & tasteless substance.

MEDICATIONS (INCLUDING PRESCRIPTIONS, OTC MEDS, VITAMINS AND HERBAL SUPPLEMENTS):

Do not keep lethal doses at home. Your doctor, pharmacist or the poison control center (1-800-222-1222) can help you determine safe quantities of medicines you need to keep on hand. Be particularly proactive by keeping prescription medications (such as narcotics and benzodiazepines) under lock and key because of their lethality and potential for abuse. See reverse side for information on how to dispose of excess medications safely.

www.MEANSMATTER.com

ABOUT MEDICATIONS (Adapted from FDA)

Medicines play an important role in treating many conditions and diseases but when they are no longer needed, they should be properly discarded to prevent harm to others. Disposal options and special instructions to follow when discarding expired, unwanted or unused medicines are listed below:

Support System's Copy **Please take home for your records.**

Medicine Take-Back Programs
Medicine take-back programs are a good way to remove expired, unwanted or unused medicines from home and reduce the chance that others may accidentally or intentionally use them. Contact your city or county government's household trash and recycling service to see if there is a medicine take-back program in your community and learn about any special rules regarding which medicines are eligible. You can also talk to your pharmacist to see if they know of other medicine disposal programs in your area.

Disposal in Household Trash
If no medicine take-back program is available in your area, you can follow these simple steps to dispose of most medicines in the household trash:

- Mix medicines (do NOT crush tablets or capsules) with an unpalatable substance such as kitty litter or used coffee grounds;
- Place the mixture in a container such as a sealed plastic bag; and
- Throw the container in your household trash

Flushing of Certain Medicines
Certain medicines may be especially harmful or potentially fatal in a single dose if used by someone other than the person for whom they were prescribed. For this reason, a few medicines have specific disposal instructions that indicate they should be flushed down the sink or toilet when they are no longer needed and when they cannot be discarded through a drug take-back program. When these medications are discarded in the sink or toilet they cannot be accidently used by children, pets or anyone else. You may have received disposal directions for these medicines with your prescription. If you did not receive disposal instructions with your prescription, you can *call the FDA at 1-888-INFO-FDA (1-888-463-6332).*

ABOUT FIREARMS **(Adapted from Maine Youth Suicide Prevention)**
A lethal weapon accessed by a person in despair can end a life in an instant! Firearms are used in five out of ten suicides in the U.S. Removing lethal means from a vulnerable person, especially a minor, can save a life. It is like keeping the car keys away from a person who consumed too much alcohol.

Who Can Help Store or Dispose of a Firearm?
Some law enforcement departments (not all) will take firearms. Some offer temporary storage, permanent disposal options or both.

What if Law Enforcement Is Not an Option?

- **Temporarily store** the firearm at the home of a trusted relative or friend. Be sure the person at risk cannot obtain the firearm before or after it is removed. NOTE: Not all people can hold the guns for you.
- **Lock** the unloaded firearm in a gun safe or tamper-proof storage box with ammunition locked in a separate location. (BETTER YET, do not keep ammunition at home). Trigger locks are sold in sporting goods stores and where firearms are sold. Some police departments offer free locks. Be sure the keys and storage box combinations are kept away from the person at risk. Remember: This does not guarantee safety. Minors are resourceful and usually figure out where their parents hide objects.
- **Do not** store firearms in a bank safe deposit box. Most states have laws that prohibit carrying a weapon into federally insured buildings such as banks.
- **Sell** the firearm following the appropriate legal guidelines.

Support System's Copy **Please take home for your records.**

Guardian please keep 1 of 2.

Respecting Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect the privacy of your health information. We call it "Protected Health Information "(PHI).

The basis for federal privacy protection is the health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. Many of our doctors follow the practices contained within this Notice.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPTERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI In order to:

- Remind you of an appointment for treatment;
- Tell you about treatment alternatives and options;
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes , for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- 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.
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purpose of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers Compensation program
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if

you are Armed Forces personnel and it is deemed necessary as appropriate military command authorities
- In connection with certain types or organ donor programs.

YOUR PRIVACY RIGHT AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosure to restrict disclosure to your health plan (insurer) if:

- The disclosure is for the purpose of carrying out payment or healthcare operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us in full.

In other situations, we are not required to abide by your request. If we do not agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNCIATON

You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or has been maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH

You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the notice electronically.

WHAT IF I HAVE A CONCERN?

If you have questions about this Notice, need additional information or have a concern that your privacy has been violated, please contact LaQuissa Wynn, Privacy Advocate at (912) 638-1999 Ext. 268.

If you have additional questions or concerns, the following agencies can be contacted to assist you:

Georgia Department of Community Health
(800) 878-6442

The Joint Commission
(800) 994-6610

Centers for Medicare and Medicaid Services
(800) 633-4227

Tricare/Value Options
(800) 700-8646

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Guardian please keep 1 of 2

SAINT SIMONS BY THE SEA

Billing Information for Patients and Families

We understand that the decision to seek treatment may be difficult, and when someone in your family is admitted, the entire period can be very emotional. Each family has unique needs and we will do our best to help address your concerns in a professional, caring, and confidential manner; answering any questions you may have.

Insurance Verification

Prior to, or at the time of registration, verification of insurance benefits will be obtained. However, this verification is not a guarantee of payment. If you have more than one insurance company, you must provide the other insurance information as well, whether benefits are available for this treatment or not. This will enable us to provide a better estimate of what your responsibility for payment will be. In most cases, prior authorization is required in order for services to be paid by your insurance company. We will seek to obtain authorization, but the patient must be eligible for benefits at the time services are provided. Your coverage is a contract between you and your insurance company; therefore the patient is responsible for any non-covered or unpaid balances.

Hospital Billing

With your consent, we will accept assignment of insurance benefits and bill your insurance company(s) for you. **If you are informed of a balance on the day you discharge, please be aware this is only an estimate. An accurate patient responsibility cannot be determined until your claim is processed and paid by your insurance company(s).**

Frequently, insurance companies request information from the patient, or the insured individual, before they will pay your claim. It is your responsibility to return this information to them as quickly as possible. If your insurance company does not pay your bill within a timely manner, (generally 30 to 45 days), we may need your assistance with contacting them directly to get the matter resolved. Failure to do so could delay reimbursement and may require us to bill you for any unpaid balances.

3rd Party Billing

Charges for psychiatric, laboratory, and medical services are billed separately and are not inclusive to the hospital bill. A copy of the same insurance information given during the time of admission will provided to submit claims for services provided.

Contact Information for Billing

The hospital billing will come from this company: **ST SIMONS BY THE SEA**
St Simons Billing Office: 912-638-1999 (Business Office)

The lab billing will come from this company: **LABCORP**
LabCorp Billing Office: 1-888-522-2677

The physician billing will come from this company: **SOUTHLAND, MD.**
~~SouthLand MD Billing Office: 1-877-777-7686 ext 2002~~

The medical billing (history/physical) will come from this company: **MACMED LLC**
MacMed, LLC Billing Office: **Brice** - 229-262-2779

Payment

Insurance co-payments and deductibles are expected prior to, or at the time of discharge; unless alternate arrangements have been made. We are aware that in some cases patients are not able to pay their full out of pocket liability prior to discharge, therefore, we will make every effort to create an affordable payment plan that takes each individual financial situation into consideration. If you are unable to take care of your total estimated balance, and need to set up a short term monthly arrangement, you would do so during the time of discharge. Our expectation is that you abide by the terms of the agreement made. If an agreement is broken, or no payment has been received 90 days from the date of service, necessary collection procedures will begin.

We are a private hospital but do understand some individuals may experience financial hardship, and may need assistance with expenses owed; therefore we do have a Financial Disclosure Statement available upon request. Please be aware that completion of paperwork does not mean you automatically qualify for assistance and supporting documentation will be required.

Our hospital accepts cash, personal checks, money orders, and all major credit cards. For your convenience, credit card payments may be made in person, by telephone, or by mail. You can also make payments on our website, www.ssbythesea.com, About Us, Patient Online Payment (ACH or Credit Card).

Overpayments

Overpayments made on your account will first be applied to any open balances on active accounts, including physician bills and accounts sent to collections. Refunds will be processed within 30 days after your claim is processed and paid by your insurance company.

Guardian please keep 1 of 1

SAINT SIMONS BY-THE-SEA

A TRADITION OF EXCELLENCE

Patient Rights and Responsibilities

At Saint Simons By-The-Sea, our mission is to provide exceptional, compassionate care in a safe environment. We want to work with you to ensure that you receive the clinical care, compassion and services you need. We want you to know your rights as well as your responsibilities during your stay at our hospital.

Patient Rights

1. The right to privacy.
2. The right to receive care in a safe setting.
3. The right to be informed of your rights and responsibilities as a patient.
4. The right to be free from all forms of abuse and harassment.
5. The right to file a grievance, and if filed, the right to a written notice that contains the name of the contact person, steps taken to look into your complaint, the results and the closing date.
6. The right to take part in the decisions and carrying out of your plan of care.
7. The right to make informed choices about your care to include being told about your health status, being involved in our care plan and treatment, and being able to request or refuse treatment. This does not mean you have the right to demand treatment or services deemed medically unnecessary or inappropriate.
8. The right to prepare advance directives and to appoint someone to make health care decisions for you if you are unable.
9. The right to have a family member or representative of your choice and your doctor notified promptly of your admission to the hospital.
10. The right to confidentiality of your medical records except when state law permits disclosure.
11. The right to authorize the release of your medical records to a designated third party and the right to access records pending the evaluation and approval of your Attending Physician or the Director of the Medical Staff.
12. The right to be free from restraint and seclusion of any form that are not medically required.
13. The right to have access to a support person of your choice and have that person included in any important communication sessions such as clinical rounds, patient education, discharge planning, etc.
14. The right to communication that you can understand. Health information will be communicated in a way to meet your needs.

Additional Rights at Saint Simons By-The-Sea

1. The right to have someone tell you about your condition.
2. The right to know the name and role of each person taking part in your care.
3. The right to know about your medication, any equipment used in your care and community resources you might need.
4. The right to have your bill explained.

Concerns, Complaints, Grievances

We want to respond to your concerns while you are at Saint Simons By-The-Sea. Please talk to your nurse, therapist, doctor or Unit Director as soon as you identify a concern. You may also speak with the Patient Advocate during business hours. During evening and weekend hours, you may ask to speak with the Nursing Supervisor. you may also express your concern in person, by phone or in writing. Your input is valuable to us in our continuing efforts to provide excellent care. We invite you to share your experiences with us.

Patient Responsibilities

1. Give complete and true details about your health, medical condition, medical history, medications, physician, advance directives and family contracts.
2. Follow the care plan agreed upon with your doctor, take part in your health care by following instruction and take responsibility for your choices.
3. Be responsible for your actions, risks and results if you refuse treatment or do not follow your doctor's orders.
4. Tell someone if you do not understand what you are being told or what you must do.
5. Respect the rights, privacy and property of others.
6. Attend scheduled activities, keep scheduled appointments and notify the doctor or therapist if you can't keep an appointment for any reason.
7. Make sure that the bills for your healthcare are paid as soon as possible. You are responsible to know the terms of your health insurance.
8. Be responsible for your own belongings. Leave expensive items or items of sentimental value at home or have a family member take them home.

Physicians providing care in this facility may NOT be employees of SAINT SIMONS BY-THE-SEA but may be independent contractors or employees of other institutions.

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

parent keep

Packing/Contraband List & Visitation

St. Simons By-the-Sea will ensure the safety of all patients and staff by defining what items are permissible, what items require staff supervision, and what items are prohibited at St. Simons By-the-Sea. Room and personal search policies are in place to ensure the safety of all parties involved in the treatment process.

DO NOT BRING (ALL PATIENTS):

- Alcohol, drugs, needles, syringes
- Smokeless tobacco and electronic cigarettes
- Lighters, matches, strikers
- Weapons
- All Medications
- Toothpicks or dental Floss
- Aerosol cans
- Fidget Spinners
- Hangers
- Metal hair combs, brushes, picks
- Glass or metal containers/items (including compacts, tobacco cans, etc.)
- Sharp objects including scissors, knives, metal nail files, nail clippers, tweezers staples, paper clips
- Razors, including electric razors with cord or electric toothbrushes
- All jewelry, except wedding band
- Pins, straight and safety, Bobbie pins, stretch headbands, dorags, etc.
- Hats of any kind.
- Tank tops, halter tops, spaghetti strap shirts
- Hooded sweatshirts or hooded shirts of any kind.
- Shoelaces, belts, scarves, drawstrings, suspenders or long tube socks
- Clothing with illegal slogans or alcohol slogans
- Steel-toed boots or flip-flops
- Underwire bras
- Toys (including dolls and stuffed animals)
- Any open containers brought from home
- Can bring 5 makeup items. Items must be unopened and in packages. Makeup cannot have any mirrors (Adults only)
- Handbags/purses, wallets, ZIP-IT Products, i.e. change purses, pencil cases, etc.
- Pencils, pens, markers, crayons
- Any electrical appliance (excluding cpap machines)
- Electronics (including cell phones, cameras, chargers, computers, tablets, headphones,mp3 players)
- DVDs, CDs
- Pornography
- Plastic bags of any size
- Outside blankets or pillows
- Magnets (including magnetic toys)
- Polymer bead/balls in products such as neck pillows, sensory toys, and stress balls
- Paracord manufactured items (soft nylon rope made up of a 32 strand woven nylon outer sheath with an inner core of yarns)
- Outside food/drinks (including gum, candy)
- Button batteries (may have in hearing aids)
- SafetyLace
- Coins or money
- Plastic bottles, plastic twist off tops or aluminum cans
- Bottles of shampoo, conditioner, body wash, lotion, bar soaps or body oils
- Dog leashes longer than 12 inches (cannot be retractable)

PLEASE BRING (ALL PATIENTS):

- 3-5 days of clothes
- List of important phone numbers (i.e. MD, therapist, etc.)
- List of ALLERGIES
- List of current medications with dosages
- C-PAP/Bi-PAP (If Applicable)

ADOLESCENTS ONLY:

- May bring school books ONLY
- Calls & visitation: biological parents/ legal guardian ONLY

Confidentiality Number _____

Patient Confidentiality Numbers

At the time of admission, each patient is assigned a confidentiality number. Federal law prohibits us from confirming or denying the presence of a patient in treatment without this number. Please have this number available when you call and/or visit. The receptionist will confirm that you have the correct number before you will be allowed to visit and before any call can be connected to the clinical areas. You should also include the confidentiality number on all mail. **Due to COVID in-person visitation is not being conducted.

Phone Calls and Visitation Times

In order not to interfere with clinical programming, incoming calls to patients are not permitted. This excludes the Adolescent Unit which accepts incoming calls from parents on designated times. If you have a question about the clinical care of your loved one, you may speak to one of the clinical staff. Patients are permitted to make outgoing calls when they are not involved in a scheduled activity. The visiting hours and phone times for each unit are listed below. **#912-638-1999**

Tranquility (Adult Mental Health Unit)

Patients are permitted to make outgoing calls when they are not involved in a scheduled activity.

Visitation

No in-person visitations at this time.

Serenity (Recovery Center/ Dual Diagnosis Unit)

Patients are permitted to make outgoing calls when they are not involved in a scheduled activity.

Visitation

No in-person visitations at this time.

Peace (Girls Adolescent Unit)

Hope (Boys Adolescent Unit)

(Parents and/or legal guardians only, please)

Outgoing phone calls *(patients can make calls to parents/guardians* only)
Monday, Wednesday, & Friday - 5:30pm-6:45pm & 7:15-8:30pm

Incoming phone calls (for parents to get updates)
Daily 10:30am-12:00pm AND/OR 4:15pm-5:30pm

Visitation

No in-person visitations at this time.

Our priority is the safety of our patients. During visitation, please keep all personal items such as bags, purses, phones, smart watches, or any sharp objects in your vehicle - you will not be allowed to keep these items with you when you visit.

Food safety standards require that no outside food be brought into the facility. Visitors will not be permitted to attend visitation if under the influence of alcohol or drugs. While we are committed to preserving our patients' right to visitation, Saint Simons By-the-Sea staff reserves the right to deny visitation to any person(s) visiting who may be deemed a threat to staff or patient safety or who otherwise refuses compliance with the program rules.

Items brought into the facility by visitors must be dropped-off at the receptionist desk in the lobby. The staff will get your belongings and bring them to the unit as soon as they can and go through them. All items brought in have to be inspected by staff for patient safety. ONLY children 12 years of age and older are permitted to visit during the designated visitation times. Please be aware that childcare will not be available when you come to visit your loved one. Two (2) visitors per patient are allowed. No Pets are allowed. Please arrive a few minutes early for scheduled visitation time as all visitors will be taken as group to the visitation area and late arrivals cannot be accommodated. If a visitor leaves visitation prior to the conclusion, they will not be permitted to return to visitation. Our policy and procedures surrounding visitation are designed to provide safe care for our patients.

Thank you for trusting us with the care of your loved one. Your compliance with these guidelines will allow us to keep the treatment of your family member our number one priority.

PEACE PROGRAM SCHEDULE (Girls)

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
6:30a	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up
7:15a– 7:45a	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•
8:00a – 8:50a	Vitals & Medications	Vitals & Medications	Vitals & Medications	Vitals & Medications	Vitals & Medications	Vitals & Medications	Vitals & Medications
9:00a – 9:50a	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)
10:00a – 10:40a	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)
11:15a – 11:45a	•LUNCH•	•LUNCH•	•LUNCH•	•LUNCH•	•LUNCH•	•LUNCH•	•LUNCH•
12:00p – 12:50p	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)
1:00p – 1:50p	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)
2:00p – 2:50p	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)
3:00p – 3:50p	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)
4:15p – 4:45p	•DINNER•	•DINNER•	•DINNER•	•DINNER•	•DINNER•	•DINNER•	•DINNER•
4:45p – 6:15p	Hygiene	Hygiene	Hygiene	Hygiene	Hygiene	Hygiene	Hygiene
6:15p – 7:15p	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation
7:15p – 8:05p	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)
8:05p – 9:00p	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation
9:00p	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out

***Incoming Phone Calls ☎ for Patient Updates – Daily: 10:30am – 12:00pm, 4:15pm – 5:30pm

***Outgoing Phone Calls ☎ by Patients – M, W, F: 5:50pm – 6:45pm, 7:15pm – 8:30pm

Updated on 3/9/2022

At this time, all visitation has been suspended until further notice.

HOPE PROGRAM SCHEDULE (Boys)

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
6:30a	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up	Wake Up/Hygiene/ Room Clean-up
7:15a– 7:45a	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•	•BREAKFAST•
8:00a – 8:50a	Vitals & Medications	Vitals & Medications	Vitals & Medications	Vitals & Medications	Vitals & Medications	Vitals & Medications	Vitals & Medications
9:00a – 9:50a	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)	Morning Goals Group (MHT)
10:00a – 10:40a	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)
11:15a – 11:45a	•LUNCH•	•LUNCH•	•LUNCH•	•LUNCH•	•LUNCH•	•LUNCH•	•LUNCH•
12:00p – 12:50p	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)	Expressive Therapy (Rec Therapist)
1:00p – 1:50p	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)	Nursing Education (Nurse)
2:00p – 2:50p	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)	Process Group (Therapist)
3:00p – 3:50p	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)	Outdoor/Leisure Activity (MHT)
4:15p – 4:45p	•DINNER•	•DINNER•	•DINNER•	•DINNER•	•DINNER•	•DINNER•	•DINNER•
4:45p – 6:15p	Hygiene	Hygiene	Hygiene	Hygiene	Hygiene	Hygiene	Hygiene
6:15p – 7:15p	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation	Leisure Activities/ Relaxation
7:15p – 8:05p	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)	Evening Goals Group (MHT)
8:05p – 9:00p	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation	Vitals/Hygiene/ Relaxation
9:00p	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out	Quiet Time/ Lights Out

***Incoming Phone Calls ☎ for Patient Updates – Daily: 10:30am – 12:00pm, 4:15pm – 5:30pm

Updated on 3/9/2022

***Outgoing Phone Calls ☎ by Patients – M, W, F: 5:50pm – 6:45pm, 7:15pm – 8:30pm

At this time, all visitation has been suspended until further notice.