THREE RIVERS
TREATMENT CENTER

CONSENT FOR TREATMENT

The undersigned authorizes Three Rivers Treatment Center, its staff, and attending physicians to render the resident all customary care, therapy, treatment, tests and procedures considered advisable, including emergency treatment and transportation to another facility if necessary. Further consent is also given for any diagnostic procedures, medical treatment, x-ray treatment, recreational activities, educational testing and therapy, and other treatment ordered by Three Rivers Treatment Center and/or attending physicians including but not limited to services provided by other Healthcare Professionals to the resident.

The undersigned affirms he/she has retained no other medications on his/her person and agrees that all medication must be dispensed by Three Rivers Treatment Center pharmacy or by a registered nurse while he/she is a resident of Three Rivers Treatment Center. The undersigned agrees that Three Rivers Treatment Center will not be responsible for the safety or care of the resident if the resident leaves the premises and will indemnify Three Rivers Treatment Center from any loss or injury which may occur as a result of leaving against medical advice.

The undersigned understand(s) that the use of reasonable restraint and/or confinement may be necessary, if severity of symptoms or behaviors warrant, in order protecting the resident from harming himself or others, or destroying property of Three Rivers Treatment Center. Should such restraint and/or confinement become necessary during the resident's admission, I/We understand and agree to indemnify Three Rivers Treatment Center its staff, physician, or other mental health professional, from any loss due to injury that may occur as a result of such restraint and/or confinement.

The undersigned acknowledges that the resident is under the control of an attending physician(s) and Three Rivers Treatment Center is not liable for any act or omission in following the instructions of said physicians.

The undersigned recognizes that certain healthcare professionals furnishing services to the resident including, but not limited to radiologists, pathologists, psychiatrists, psychologists, physical therapists, and/or licensed social workers may be independent contractors and may not be employees or agents of Three Rivers Treatment Center. The undersigned further recognizes that the resident may be billed separately by their attending physicians and/or other healthcare professionals for their services provided.

CONSENT FOR ADMISSION

The undersigned acknowledges that no guarantee or assurance has been made to them, or the resident, as to the results of any services provided to the resident, including but not limited to therapy, treatment, tests or procedures, while admitted to Three Rivers Treatment Center. The undersigned further understands that, unless otherwise disclosed, Three Rivers Treatment Center does not employ physicians and that the resident's admitting physician(s) and any other physician who may consult or provide services to the resident during his admission are not employed by and are not agents of Three Rivers Treatment Center, but are independent physicians who exercise their judgment in the services they render to residents.

The undersigned authorizes the facility to search the personal belongings of the resident when it is reasonable believed that the resident may be or is in possession of an item or items which may be dangerous to his/her health or to the health of others. If any are found, it is understood that they will be maintained in a secure place and returned to the resident at discharge unless otherwise therapeutically indicated by the attending physician.

The undersigned consents to taking of photograph(s) for the purpose of identification. The photograph(s) may be permanently retained in the resident's medical record.

The undersigned releases Three Rivers Treatment Center from any liability for the loss or damage of personal property and money kept in the resident's room during his/her hospitalization. Furthermore, it is understood and agreed that Three Rivers Treatment Center shall not be liable for loss or damage to money, personal valuables or other articles unless deposited with the accounting office for safe keeping.

APPLICATION FOR VOLUNTARY ADMISSION

I hereby file with the administrator of Three Rivers Treatment Center, this requires to be admitted as a voluntary resident. In doing so, I agree to submit myself to the custody of the hospital for diagnosis, observations, care and treatment until the day of discharge as determined by the attending doctor and treatment team. If I desire to leave prior to the discharge date as set by the doctor and treatment team, I will submit a written request to the administrator which will be acted on within seventy-two (72) hours.

THREE RIVERS
TREATMENT CENTER

CONSENTS FOR RELEASE OF INFORMATION

The undersigned authorizes Three Rivers Treatment Center to release all resident information, including specific information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the resident is being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS), while at Three Rivers Treatment Center , to any insurance company, and/or third party payors or representative providing coverage for this admission, or to any Three Rivers Treatment Center representative including, but not limited to Three Rivers Treatment Center employees, attending physicians, other healthcare professionals or organizations. The information may not be released to any other person or entity unless the undersigned so authorizes.

The undersigned acknowledges that such disclosure shall be limited to information that is reasonable necessary for the discharge of the legal or contractual obligations of the person(s) or entities to which the information is released.

The undersigned further authorizes Three Rivers Treatment Center to release information for the purpose of obtaining preauthorizations for treatment and concurrent review and to release that information to medical review agencies, and/or third party payors providing coverage or having responsibility for the admission.

I acknowledge that I have been given a copy of the "Notice of Privacy Practices". I understand that if I have any questions or complaints I may contact the facility privacy officer.

Youth and guardian initials _____

GUARANTEE OF PAYMENT

The undersigned, hereby agree(s) to guarantee the payment of the bill for services rendered by Three Rivers Treatment Center. All charges for services rendered are due within 30 days unless other financial arrangements have been approved. Should benefits be withheld or denied by an insurance company, the guarantor is responsible for any payment in full to Three Rivers Treatment Center and physician. I agree to pay collection costs and reasonable attorney fees incurred by Three Rivers Treatment Center and physician during the collection process. I further agree to pay for damages to hospital property by the youth. I acknowledge that I will be billed separately for services rendered by physicians, psychologists, and other licensed professionals who are not agents of the hospital and accept full responsibility and guarantee payment for all charges incurred.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of hospital and medical services rendered or to be rendered by Three Rivers Treatment Center to the extent permitted by law, I hereby (1) irrevocable assign, transfer and set over to Three Rivers Treatment Center all of my rights title and interest to medical reimbursement, including, but not limited to (III) the right to designate a beneficiary, and dependent eligibility and (IV) to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by Three Rivers Treatment Center during the pendency of the claim for this admission. Such irrevocable assignment and transfer shall be for the recovery on said policy(ies) or insurance, but shall not be construed to be an obligation of Three Rivers Treatment Center to pursue any such right of recovery. I hereby authorize the insurance company(ies) or third party payor(s) to pay directly to Three Rivers Treatment Center all benefits due for services rendered.

GOVERNMENTAL PROGRAMS

The undersigned hereby authorizes any agency or employee of the U.S. Government, any state government or municipal government to release to the facility , it's employee's and it's attorneys any and all information concerning any government program under which the youth is or may qualify to receive benefits due and further authorize payment of any and all such benefits direct to the facility.

HIV/HEPATITIS B OR C TESTING

The youth is hereby informed in accordance in Section 32.1-45.1of Code of Virginia, 1950, as amended, that if provision of health care services to the resident at this facility exposes any person employed by or under the direction and control of this facility or any health care provider, to the resident's body fluids in a manner which

may transmit the immunodeficiency virus or HIV or Hepatitis B or C viruses and to the release of such test result to the person exposed.

PERSONAL BELONGING AND BODY SEARCH

I understand that certain items are restricted from my possession in order to promote a safe and therapeutic environment. Prior to admission, I will identify any contraband items such as lighters, pocket knives, etc. that I have and I will give it to the admission staff or send them home with my parent/guardian. Upon admission to the facility, return from pass/visitation and/or when contraband is suspected to be present, I understand that I and/or my belongings may be searched. I also understand that Three Rivers Treatment Center and its affiliates do not assume responsibility for lost or damaged items, money and valuables not secured in the facility safe.

CONSENT FOR FOLLOW-UP CONTACT

The undersigned consent(s) to Three Rivers Treatment Center staff members, other healthcare professionals, or their representatives contacting the resident or a family member by telephone in approximately one month to one year. Three Rivers Treatment Center makes periodic contact with those who have used its services, using the information to improve its services to residents and to make sure that Three Rivers Treatment Center is addressing residents' needs. Specific responses are not disclosed; only summary information is assembled. This contact may also include, but not be limited to, information sent from the Three Rivers Treatment Center on current educational programs and newsletters.

ACKNOWLEDGE RECEIPT OF RESIDENT RIGHTS

The undersigned acknowledge(s) that a copy of the resident rights bad been given to them, that these rights have been explained and that they understand these rights.
Youth and guardian initials _____

CONSENT FOR VIDEO TAPE & PHOTOGRAPHY

The undersigned hereby authorize(s) Three Rivers Treatment Center the attending physician, and/or psychologist to videotape group or individual therapy sessions. It is my understanding that these tapes will be used as a part of my treatment at this hospital and that they may also be used for the purpose of instruction to other professionals within the hospital. I understand that I will be informed before such sessions are videotaped.
The facility utilizes video surveillance throughout the facility for monitoring for patient safety and risk management. In an effort to maintain confidentiality, the facility provides for securing all videos.
I consent to be photographed and authorize the use of these photographs as part of my medical record for the purpose of youth identification.

EMERGENCY TREATMENT

I hereby authorize this facility, in case of an emergency, to seek outside medical and/or dental treatment at an appropriate facility. I further authorize the receiving facility to provide emergency medical and/or dental treatment, including emergency medications ordered by a physician. **Youth and guardian initials**

_____

DISCHARGE POLICY INFORMATION

The undersigned understands that it is the policy of Three Rivers Treatment Center to attempt to provide a structured therapy regimen with effective quality treatment. If the treatment regimen is not completed prior to the exhaustion of resident'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 copayment liability. It is **NOT** Three Rivers Treatment Center's policy to discharge or transfer residents or end treatment regimen simply because insurance benefits have been exhausted.

THREE RIVERS
TREATMENT CENTER

APPLICABILITY TO OTHER PROVIDERS

The undersigned agree(s) that in the event other healthcare professional providers, including but not limited to other hospital(s), furnish services to the resident while in Three Rivers Treatment Center the consent(s), assignment(s), guarantee(s) and release(s) herein above set out shall apply to such other providers and services.

ADVANCED MEDICAL DIRECTIVE

I hereby acknowledge an ADVANCE MEDICAL DIRECTIVE has been explained to me and I have received written information concerning advanced medical directive. I have been advised about my right to accept of refuse medical treatments. I have been informed of my right to formulate and ADVANCE MEDICAL DIRECTIVE. I understand that I am not required to have an advance medical directive in order to receive treatment. I understand that the terms of any directive I have executed will be followed by this facility to the extent permitted by the law. ☐N/A ☐Yes ☐No

Please initial I HAVE _____ I HAVE NOT _____ executed an advance medical directive.

A copy of my advance medical directive has been given to this facility: ☐N/A ☐Yes ☐No

ADVANCED PSYCHIATRIC DIRECTIVE

I hereby acknowledge an ADVANCE PSYCHIATRIC DIRECTIVE has been explained to me and I have received written information concerning advanced psychiatric directive. I have been advised about my right to accept of refuse psychiatric treatments. I have been informed of my right to formulate and ADVANCE PSYCHIATRIC DIRECTIVE. I understand that I am not required to have an advance medical directive in order to receive treatment. I understand that the terms of any directive I have executed will be followed by this facility to the extent permitted by the law. ☐N/A ☐Yes ☐No

Please initial I HAVE _____ I HAVE NOT _____ executed an advance psychiatric directive.

A copy of my advance medical directive has been given to this facility: ☐N/A ☐Yes ☐No

I have read the above information and have been given the opportunity to ask questions I have related to each item. My signature below indicates my understanding of this information, and where applicable, my permission.

	Name	Relationship/Title	Signature	Date	Time
Parent/Guardian					
Guarantor					
Youth		self			
Facility Staff					

Three Rivers Treatment Center
Placement Agreement

_____ (legal guardian) agrees to place _____(youth) at:

Three Rivers Residential Treatment center, located at 231 Hickory Road Kenbridge, VA 23944.

The youth shall remain Three Rivers Treatment Center for a period of _____or until placement is terminated.

Three Rivers Treatment Center will have physical custody (care and supervision) of the child with the child remaining in the legal custody of Legal Guardian.

Three Rivers Treatment Center will:

- Provide living quarters, food, supervision, and guidance.
- Update the legal guardian on the progress and development of the child and if the child is meeting projected goals.
- See that the child receives routine medical/dental and psychiatric care with permission of the legal guardian.
- Discharge the child at the agreed time or give the legal guardian two weeks notice prior to discharge, except in the case of immediate discharge, where the child will go to his emergency placement.
- Will ensure educational services are provided through the local school system, private day school, adult educational facilities, or other applicable means as deemed necessary by the local education agency (LEA) and disciplinary team. Three Rivers Treatment Center will make contact with the LEA within two business days to ensure prompt enrollment. The Director and/or case manager will make contact with the school division superintendent in order to notify them and let the school know that the student is a resident of Three Rivers Treatment Center. Three Rivers Treatment Center staff will ensure that resident receives supplemental educational services if needed through the local school system that is deemed necessary by the client's academic need.

The Legal Guardian shall:

- Give permission to Three Rivers Treatment Center with this agreement to authorize necessary medical/dental care and consent to emergency medical and surgical and/or hospitalization where the legal guardian is unable or cannot be reached with the legal guardian being notified at the earliest possible time.
- Cover the expenses of medical/dental and psychiatric care, including prescriptions.
- Give two weeks notice prior to permanent removal of the child from Three Rivers Treatment Center.
- Have an emergency placement available for removal of the child from Three Rivers Treatment Center within 48 hours of notice, if it is in the best interest of the child or the facility.

Emergency Placement Facility: Poplar Springs Hospital for acute psychiatric needs and Southside Community Hospital for acute medical needs, or next closest facility with an available bed.

Scheduled appointments or absences.

Child has permission to call: To complete phone list with nurse/therapist.

The legal guardian plans to visit the child _____times per _____.

The above agreement will be funded by _____, for the child's care at Three Rivers Treatment Center.

_____ _____
Legal Guardian Date

_____ _____
Representative of Agency Date

_____ _____
Three Rivers Treatment Center Representative Date

THREE RIVERS
TREATMENT CENTER

PRIVACY NOTICE

Protecting the privacy and confidentiality of information about our residents in very important to Three Rivers Treatment Center (hereafter called 3RTC). Accordingly, we strive to comply with the applicable state and federal law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of Protected Health Information and to provide you with notice concerning our privacy practices. In the event that another law, other than HIPAA, prohibits or limits our use and disclosure of Protected Health Information, we will comply with the more stringent standard. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy as necessary and to make the new Notice effective for all Protected health Information maintained by us. If we make material changes to our privacy practices, we will provide you with a copy.

Definitions

Protected Health Information (PHI) means individually identifiable health information, as defined by HIPAA that is created or received by 3RTC. This information contains demographic information about you such as your name or date of birth as well as information about your physical or mental health, services provided by others prior to your admission.

Use and Disclosures

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclosure PHI will fall within one of these categories.

Use for Treatment – We routinely share your PHI within our organization to provide treatment for you. It is our policy to limit this to the minimum necessary information in order to provide treatment to you.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have already taken action in reliance upon the authorization, or that authorization was obtained as a condition of admission for the purpose of treatment.

Use and Disclosures for Payment – We may use and disclose your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims.

Use and Disclosure for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities related to Quality Improvement, Medical Staff Credentialing, or other staff or committee functions

Family and Friends Involved in Your Care – We will not routinely disclose PHI to your family and friends, even when they have been involved in your treatment, without your prior authorization. If you are incapacitated or we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals.

Business Associates – are individuals or companies which act as our agent in treatment, payment or healthcare operations. Examples of these would include the reference laboratory companies and computer companies. At times it may be necessary for us to provide specific PHI to one or more of these outside persons or organizations.

Other Products & Services – We do not use your PHI for marketing purposes of any kind. We will not disclose your PHI to any business associate for that purpose.
Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization

+ We may use or disclose your PHI when required by law. For example, 3RTC may be required by law to use or disclose your PHI when responding to a court order
+ We may disclose your PHI for public health activities, such as reporting a required communicable disease
+ We may disclose your PHI to the proper authorities if we suspect child abuse or neglect
+ We may disclose your PHI if authorized by government oversight agency or any other regulatory agency. For example, a Medicare/Medicaid audit
+ We may disclose your PHI for the proper law enforcement purposes. For example, if a crime is committed by you or upon you while you are in treatment
+ We may disclose your PHI to coroners or medical examiners consistent with state law
+ We may disclose your PHI if we believe that you or somebody else might be in danger and that the disclosure would avert a serious threat to health or safety
+ We may use or disclose your PHI if you are a member of the military as required by armed forces services

Rights that You Have
Access to your PHI – You have the right to copy and/or inspect certain portions of your PHI that we maintain. Requests must be in writing and must state that you want to have access to your PHI. Your request must be approved by your attending physician and may be denied if it is contrary to your welfare. Access request forms are available from the Health Information Department. We may charge you a fee for copying and postage.
Amendments to your PHI - You have the right to request that PHI we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reason for the amendment/correction request. Amendment request forms are available from the Health Information Department. *Accounting for Disclosure of Your PHI* – You have the right to receive an accounting for certain disclosures made by us of your PHI. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from the Health Information Department. We may charge you a fee for the requests.
Restriction of the Use and Disclosure of your PHI – You have the right to request restrictions on certain communications of our use and disclosure of your PHI for treatment, payment and health care operations. Your request must describe in detail the restriction you are requesting. HIPAA does not require us to agree to your request but we will accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agree-to restriction. Requests for restriction (or termination of existing restrictions) may be made to any 3RTC Staff member involved in your care and treatment.

Requests for Confidential Communication – You have the right to request that communications regarding your PHI be made by alternative means or alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. Requests for confidential communications must be in writing, signed by you or your representative, and filed with 3RTC.

Right to a Copy of the Notice – You have the right to a copy of this Notice upon request by contact any Three Rivers Staff member.

Complaints – If you believe your privacy rights have been violated, you may file a complaint with 3RTC. You may also file a complaint in writing with the Secretary of the US Department of Health and Human Services in Washington, DC, within 180 days of a violation of your rights. There will be no retaliation for your complaint.

For Further Information

If you have questions or need further assistance regarding this Notice, you may contact our Compliance Office at 231 Hickory Road, 3RTC VA 23944

Effective Date: This notice is effective January 3, 2013

Parent Guardian Signature: _____Date: _____Time: _____

Staff Signature: _____Date: _____Time: _____

THREE RIVERS
TREATMENT CENTER

Prior Week Behavior Assessment

Name of Youth: _____ Date: _____

Please check all that apply, describing the child's behaviors that have occurred within the past **SEVEN** days prior to RTC admission.

BEHAVIOR	FREQUENCY	LAST DATE THIS OCCURRED	DESCRIBE BEHAVIORS
□ Suicidal ideation/attempt	□ daily □ monthly □ weekly □ not often		
□ Homicidal ideation/attempt	□ daily □ monthly □ weekly □ not often		
□ Self-injurious/cutting	□ daily □ monthly □ weekly □ not often		
□ Fire-setting	□ daily □ monthly □ weekly □ not often		
□ Cruelty to animals	□ daily □ monthly □ weekly □ not often		
□ Stealing	□ daily □ monthly □ weekly □ not often		
□ Gang involvement	□ daily □ monthly □ weekly □ not often		
□ Provocation	□ daily □ monthly □ weekly □ not often		
□ Defiant/Oppositional	□ daily □ monthly □ weekly □ not often		
□ Explosive	□ daily □ monthly □ weekly □ not often		
□ Low frustration tolerance	□ daily □ monthly □ weekly □ not often		
□ Impulsive	□ daily □ monthly □ weekly □ not often		
□ Substance Use	□ daily □ monthly □ weekly □ not often		
□ Runaway risk	□ daily □ monthly □ weekly □ not often		
□ Sexual acting out	□ daily □ monthly □ weekly □ not often		

BEHAVIOR	FREQUENCY	LAST DATE THIS OCCURRED	DESCRIBE BEHAVIORS
□ Sexual abuse	□ daily □ monthly □ weekly □ not often		
□ Academic issues	□ daily □ monthly □ weekly □ not often		
□ Destructive	□ daily □ monthly □ weekly □ not often		
□ Aggressive/Injuries toward others	□ daily □ monthly □ weekly □ not often		
□ Self-esteem issues	□ daily □ monthly □ weekly □ not often		
□ Blames self/others	□ daily □ monthly □ weekly □ not often		
□ Poor Hygiene	□ daily □ monthly □ weekly □ not often		
□ Social withdrawal/isolation	□ daily □ monthly □ weekly □ not often		
□ Anxiety	□ daily □ monthly □ weekly □ not often		
□ Fearfulness/phobias	□ daily □ monthly □ weekly □ not often		
□ Obsessive/Compulsive/ Intrusive thoughts	□ daily □ monthly □ weekly □ not often		
□ Sadness	□ daily □ monthly □ weekly □ not often		
□ Sleep disturbance	□ daily □ monthly □ weekly □ not often		
□ Bizarre thoughts/Delusions	□ daily □ monthly □ weekly □ not often		
□ Hallucinations	□ daily □ monthly □ weekly □ not often		
□ Paranoia	□ daily □ monthly □ weekly □ not often		
Other			

THREE RIVERS
TREATMENT CENTER

OTHER HEALTH INSURANCE QUESTIONNAIRE

1. **Does the youth have any other Health Insurance Coverage?** ☐ Yes ☐ No

2. **If yes, please complete the following information:**

   a) Name of Insurance Company: _____

   b) Name of Policy Holder: _____

   c) Policy Number_____ Effective Date of Coverage: _____

   d) Type of Coverage: Medical/Surgical _____ HMO_____ PPO _____

   e) Other, please explain _____

3. **If the youth has no other health insurance, please complete the following:**

   Has the youth been covered by any other health insurance in the past three years?
   ☐ Yes ☐ No

If yes, please indicate the following information:

a) Name of Insurance Company _____

   Termination date of coverage _____

b) Name of Insurance Company _____

   Termination date of coverage _____

Youth Signature _____ Date _____

Legal Guardian signature _____Date _____

Witness _____Date _____

THREE RIVERS
TREATMENT CENTER

OVER THE COUNTER (OTC) MEDICATION CONSENT

On occasion over the counter (OTC) items are ordered for adolescents to meet their general needs, i.e. facial cleaners, chapstick, dandruff shampoo, antibiotic ointments, etc.

I,_____,(guardian) give permission for the following items to be given to _____, (youth) to meet hygiene/comfort needs provided by OTC items. These items generally include but may not be limited to the following items:

- ☐ Chapstick
- ☐ Carmex
- ☐ Mederma Cream
- ☐ Oxy Pads
- ☐ Foot Powder
- ☐ Dandruff Shampoo
- ☐ Cough drops/lozenges

Comments: _____

Signature: _____ Relationship: _____ Date: _____

Witness: _____ Status: _____ Date: _____

Three Rivers Treatment Center
THERAPEUTIC EXPOSURE CONSENT

As part of treatment, Three Rivers Treatment Center, offers youth the opportunity to participate in a variety of off-site, therapeutic outings designed to develop self-confidence, group cohesion, teamwork, and group problem solving skills. In addition to fostering personal confidence and mutual support between group members, the outdoor/offsite activities allow participants the opportunity to improve agility and physical coordination, and to develop an increase familiarity with the natural world.

Each activity is conducted by staff qualified to oversee patient's safe participation in the activity. In consenting to participate in any of the below activities, the patient agrees to use safety equipment and observe procedures as directed by the staff. By nature, however these activities could entail falling and water hazards, and expose participants to risks of harm commonly associated with outdoor setting, including, but not limited to, drowning, bone fractures, minor cuts, contusions, insect bites, and sprains. While Three Rivers Treatment center believes that these activities can be highly effective elements of a youth's treatment program, participation in them is not mandatory.

I, the undersigned, understand that there are risks associated with my participation in the activities checked below. I understand Three Rivers Treatment Center cannot eliminate all of these risks even though they will try to lessen them to the extent possible. I understand that I am responsible for following the staff's directions and that if I do not follow directions, I will increase my risk of injury. I understand that my participation in these activities is voluntary and that I am not required to participate. I am willing to assume the risks that have been disclosed to me and risks that may be unforeseen. I have had a chance to ask questions about the activities and feel that I know what risks I am choosing to accept. Therefore, by signing this, I confirm my informed consent to participate in the outings checked below.

☐ Swimming
☐ Outings

	Name	Relationship/Title	Signature	Date	Time
Parent/Guardian					
Youth		self			
Facility Staff					

Three Rivers Treatment Center

Youth Rights

You must be informed of your rights upon admission, and annually thereafter, while in the program. You have the right to see and get a copy of the Human Rights Policy and the Rules of Conduct upon request.

You have the right:

- To be treated with dignity and respect.
- To speak to others in private.
- To be told about your treatment.
- To have a say in your treatment.
- To have your complaints resolved.
- To say what you prefer.
- To ask questions about your rights.
- To get help with your rights.

If you have any problems, concerns, or complaints we encourage you to speak to any staff member or Clinical Director. If you feel that you cannot speak to your community staff or are not satisfied with the response to your concern, please feel free to contact your Resident Advocate.

Three Rivers Treatment Center is committed to ensuring the protection of your rights. We have appointed a Resident Advocate to act on behalf of all residents. The role of the Resident Advocate is to listen to any concern, complaints, or suggestions that you may have as an objective third party. The Resident Advocate will listen and assist you in resolving any conflicts or complaints that have not been resolved on the unit or with the Clinical Director. Your Resident Advocate is Nancy Hudgins.

Human Rights Advocate

The state of Virginia, through the Department of Behavioral Health and Developmental Services, has appointed person to act on behalf of consumers of services licensed by this department. The Human Rights Advocate is available to assist you if your concerns or complaints are not resolved to your satisfaction by the hospital.

If you have attempted to resolve any issues or concerns with the unit staff, Clinical Director, Risk Manager, and/or Resident Advocate and have been unsuccessful, then you may contact the local Human Rights Advocate for further assistance. Your Human Rights Advocate is Tammy Long. You can contact her at 434-767-3532.

THREE RIVERS
TREATMENT CENTER

Youth Safety

We are continually pursuing excellence in our healthcare service delivery. To assist us in maintaining the highest quality care, Three Rivers Treatment Center encourages all members of the general public, or the youth who has a concern regarding patient safety, to notify Three Rivers staff on duty or any member of our administrative team. If you have discussed your concern with the staff on duty and you believe the issue has not been resolved please contact our Risk Manager, Jennifer Bennett, at 434-676-1378 ext. 117.

If your concerns can not be resolved through our Risk Manager you may contact the Joint Commission's Office of Quality Monitoring. You may provide your name and contact information or you may report anonymously.

You may contact the Joint Commission's Office of Quality Monitoring at 800-994-6610.

I have received and understand the information given to me regarding my rights as a youth here at Three Rivers Treatment Center, the role of Resident Advocate, how to contact the Resident Advocate, the role of the Human Rights Advocate, how to contact the Human Rights Advocate, and how to contact the Joint Commission's Office of Quality Monitoring.

_____	_____	_____
Youth Signature	Date	Time
_____	_____	_____
Legal Guardian	Date	Time
_____	_____	_____
Witness	Date	Time

THREE RIVERS
TREATMENT CENTER

To our parents, residents, and community,

Please understand that our top priority at Three Rivers is safety. We understand that the list below will pose some challenges, and we are prepared to help problem solve. We appreciate your support us as we help our students and residents navigate through a tough time. Please let us know if you have any questions.

Contraband Guidelines for Three Rivers Treatment Center & Three Rivers Academy

- Substances that have been removed from their original packaging
- Weapons- guns, knives, chains, clubs, bats, etc…
- Items with sharp points and edges such as knives, scissors, razors, nail clippers, metal files, tweezers, cans, wire hangers, needles, safety pins and any other related items that staff may feel are unsafe on the unit
- Glass bottles or ceramics, including mirrors and perfume bottles
- Spike or over 1 inch heeled shoes; steeled toe shoes/boots, shoes/boots with points
- Inappropriate clothing (gang related, glorifying substance use or negative message)
- No sewing or craft equipment (needles, scissors, etc.)
- Checks, credit cards and money.
- Recording devices, this includes cameras, cell phones, tape recorders and video camcorders.
- Baby powder/Vaseline, or Petroleum Jelly
- MP-3 players/IPods, electronic devices, cameras, laptops, cell phones, tape recorders and video cameras
- No sexually explicit materials
- Burned, broken compact discs or digital video discs
- Plastic compact disc cases
- Metal paper clips, hangers, or staples
- Metal cans
- Belts, shoelaces, drawstrings, and scarves
- Outside food/drink, includes candy and gum
- Sunglasses, bandannas and sweatbands
- Ink pens, full length pencils
- No items with cords
- Drugs, medications, alcohol
- Full length pencils & erasers
- Products with alcohol in the top 3 ingredients
- Watches/Jewelry

The following items may be used as staff observes for RTC residents:

- Electrical appliances such as blow dryers, curling irons, electric razors.
- Aerosol articles (mousse, shaving gel, hairspray and like products)

Any item may be removed by an administrator, charge nurse or supervisor if deemed unsafe.
This list is subject to change. Revised 2/21/2017

Youth _____ **Date** _____ **Staff Initial** _____
Date_____

Parent/Guardian _____ **Date** _____

THREE RIVERS
TREATMENT CENTER

Acknowledgement of receipt and understanding of Three Rivers Treatment Center's use of restraint

It is the policy of Three Rivers Treatment Center to treat each patient with dignity and respect, always using the least restrictive level of intervention, while maintaining a safe, therapeutic environment for all youth, staff and visitors. We find that the use of restraint is always to be a last resort and will only be implemented when there is immediate danger to someone's safety.

Policies and procedures are in place for restraint and comply with all applicable laws, accrediting the body criterion and standards, patient rights, and community and professional standards.

Definitions:
Restraint: Three Rivers Treatment Center follows that paradigm of TOVA when physical restraints are required for safety. The facility does not use mechanical restraints.

Seclusion: Three Rivers Treatment Center does not practice seclusion, which is the involuntary placement of an individual in an area that he or she is prevented from leaving.

Use of relaxation room: There are multiple relaxation rooms on each community and in the main hallways of the facility for our youth to use to regain self-control during overwhelming times.

Key points:

1. Restraints are an emergency intervention, the parent/guardian will be contacted as soon as possible during or after the intervention.
2. Each patient and legal guardian will receive a copy of the Three Rivers Treatment Center's policy on restraint at the time of admission. At this time you will have an opportunity to review and ask questions about the policy. Your signature below acknowledges your receipt and understanding of this process and contents of the policy.
3. At the time admission, your treatment team will discuss and identify techniques to help manage overwhelming situations and emotions when you may at risk to harm yourself or others. This information will become part of your Behavior Support Plan and it will be integrated into your treatment plan.
4. Parents/guardians will be notified within 24 hours of an episode of a restraint.
5. The reduction of the use restraint at Three Rivers Treatment Center is an ongoing process for the leadership team along with Youth Council Advisory Board and Parent Advocates. These efforts include training, education, and performance improvement initiative with all levels of staff.

YouthSignature: _____Date: _____

Parent/Guardian Signature : _____Date: _____

Staff Witness: _____Date: _____

THREE RIVERS
TREATMENT CENTER

Restitution for Property Damage

We understand that being out of the safety of your home and away from your comfort zone is difficult, that is why we place such a high value on our environment. We want you to feel as comfortable as possible. We take it seriously if a youth takes that comfort away because of property damage. Not only does property damage take away from how the facility looks, but it can often cause trauma for those who may witness the damage taking place. It is for this reason that Three Rivers Academy and Treatment Center policies include the concept of restitution for property damage.

When a youth demonstrates out of control behaviors that result in property damage, they may be required to participate in community service. The specific plan of service will be determined by the treatment team. This plan may result in diminished community privileges based on the extent of the property damage. Restitution may also be applied.

Restitution has monetary and legal components. The choice to destroy property will lead to a bill for replacement of damaged property (please see the itemized list below); and facility administration will also determine if law enforcement needs to be contacted per VA code 18.2-137:

Virginia Law 18.2-137 Destruction of Property and Vandalism treats vandalism as a Class 6 felony when the value of or damage to the property is $1,000 or higher, and as a Class 1 misdemeanor when the value of or damage to the property is less than $1,000.

Examples include, but may not be limited to:

Damage to drywall:	$200 per hole
Damage to artwork or bulletin board frames	$100
Damage to furniture including graffiti	$500
Damage to computer, telephone, or other equipment	$500

Signature below indicates the Three Rivers Treatment Center has reviewed the facility procedure for restitution and that the financial and legal consequences connected to property destruction are understood.

	Name	**Relationship/ Title**	**Signature**	**Date**	**Time**
Parent/ Guardian					
Youth		self			
Facility Staff					

Date _____

Dear _____,

My child _____ was admitted for non-educational reasons to Three Rivers Treatment Center on _____. I would like to schedule an Individualized Education Program (IEP) meeting within the next ten business days. The purpose of the meeting is to amend my child's IEP to reflect: my child's current level of performance; any necessary revised or added IEP goals; the level and nature of services my child needs at this time; how these services will be provided and by whom while my child is receiving treatment at Three Rivers Treatment Center.

I would also like a representative of Three Rivers Treatment Center to participate in the IEP meeting so that the facility can provide and understand information regarding my child's current level of performance, educational needs and other pertinent IEP information.

Thank you for quickly setting up this meeting. Please contact me at _____and Dr. Wes Eary at Three Rivers Treatment Center at 434-676-1378 or wes@3rtc.com to schedule the time and date of the IEP meeting.

Sincerely,

_____

Signature of Parent/Legal Guardian

THREE RIVERS
TREATMENT CENTER

Parental or individual consent for administering the Woodcock-Johnson III Test of Achievement

I give permission to Three Rivers Academy/Treatment Center to proceed with the administration of the Woodcock-Johnson III Test of Achievement, for my child, _____. This information may be shared with other educational providers and agencies with the written permission of the parents/guardian.

Student Signature: _____Date: _____

Parent/Guardian Signature : _____Date: _____

Staff Witness: _____Date: _____

I do not give permission for Three Rivers Academy/Treatment Center to proceed with the administration of the Woodcock-Johnson III Test of Achievement for my child, _____.

Student Signature: _____Date: _____

Parent/Guardian Signature : _____Date: _____

Staff Witness: _____Date: _____

THREE RIVERS
TREATMENT CENTER

HAIR SERVICES PERMISSION SLIP

I give permission for _____ to have his/her haircut and/or washed and styled by a Licensed Cosmetologist. I understand that all hair services will represent no drastic change in the patient's present appearance and will be for grooming purposes only.

Specific instructions/notes:

_____

_____

_____

_____ _____

Guardian Signature Date

_____ _____

Witness Signature Date

THREE RIVERS
TREATMENT CENTER

Permission for Use of Music Technology

I _____ guardian of _____ give permission for him/her to use music technology provided by me when appropriate and approved.

I understand:

1. 3RTC does not supply any equipment related to music technology.
2. The youth is responsible for following all rules that apply to music technology.
3. The youth is not to share this device with other youth for any reason.
4. 3RTC is not responsible for damage to or loss of device.
5. Parents and guardians are expected to be aware of the content of the music on the device and give consent for the minor to listen to the content loaded on the device.
6. The youth and I are responsible for the content, maintenance and upkeep of the device. 3RTC will not update, maintain, or make changes to the device.
7. The use of the device is solely based on safety and appropriateness and it is not to detract from the program but, should enhance personal soothing.
8. The device is not to contain any glass internally or as part of the face.
9. If deemed a safety concern, staff reserves the right to remove the item at any time.

Parent/Guardian signature: _____ Date: _____ Time: _____

THREE RIVERS
TREATMENT CENTER

Authorized Contact List

Person	Relationship	Consent for mail/phone contact	Address	Phone numbers	Guardian or Clinician Initials
		☐mail ☐ phone ☐ visitation		Best: ____________________ Alt:______________________ Alt:______________________	
		☐mail ☐ phone ☐ visitation		Best: ____________________ Alt:______________________ Alt:______________________	
		☐mail ☐ phone ☐ visitation		Best: ____________________ Alt:______________________ Alt:______________________	
		☐mail ☐ phone ☐ visitation		Best: ____________________ Alt:______________________ Alt:______________________	
		☐mail ☐ phone ☐ visitation		Best: ____________________ Alt:______________________ Alt:______________________	
		☐mail ☐ phone ☐ visitation		Best: ____________________ Alt:______________________ Alt:______________________	
		☐mail ☐ phone ☐ visitation		Best: ____________________ Alt:______________________ Alt:______________________	
		☐mail ☐ phone ☐ visitation		Best: ____________________ Alt:______________________ Alt:______________________	
		☐mail ☐ phone ☐ visitation		Best: ____________________ Alt:______________________ Alt:______________________	

THREE RIVERS
TREATMENT CENTER

Consent for Transportation Off Grounds

I hereby grant Three Rivers Treatment center and Academy to transport _____ in a Three Rivers vehicle off facility grounds while placed in the services of 3RTC/3RTA. I understand that while this child is enrolled in services he/she will be transported off facility grounds in vehicles by approved staff when necessary for medical appointments, off-site activities, community outings, emergencies or other off campus purposes.

I have read this consent form. I have had the opportunity to ask questions about this consent form and received answer to those questions. My consent for off-grounds transportation is effective as of the date of admission and will continue through the date of discharge.

Please list a person who may know where to each you when you are not at home:

Name: _____ Phone: _____

	Name	Relationship/Title	Signature	Date	Time
Parent/Guardian					
Youth		self			
Facility Staff					