TFS Kennedy Clinic
For Adults with Special Needs

Dear Patients, Families, Guardians/Conservators, and Care Givers,

Here at the TFS Kennedy Clinic, we strive to provide compassionate, holistic healthcare to patients with intellectual and developmental disabilities. We look forward to providing all of your primary healthcare needs. In order to provide you with comprehensive care, it is necessary we maintain current and updated health information. Please complete the attached patient packet to initiate care and continual care here at the clinic. This information needs to be completed annually.

In order for us to provide comprehensive care, we are requesting the following items:

1) **Legal guardian to complete New Packet Information for the clinic.**
2) **Copy of guardianship/conservatorship papers or Medical POA documents from court**
3) **Copy of current insurance cards**
4) **Copy of immunization record**
5) **Record of diagnosis of an ID or DD**
6) **List and dosage of all current medications taken**
7) **Financial statement packet completed and signed in all places**

Please ensure that each page of the patient packet is completed and signed by the patient/legal guardian as required. All medical information needs to be checked and the forms signed. After receiving the completed packet back at the clinic, the TFS Kennedy clinical review committee will review and sign the documents and you will receive a call to schedule an appointment, therefore, it is important that we receive the packet back timely into the office signed and completed with all documents requested.

If you should have any questions, please do not hesitate to contact our office. We look forward to seeing you soon.

Sincerely,

JoAnnie Bryant, MHRM
Clinic Manager

831 Seven Oaks Blvd • Smyrna, TN 37167 • Phone: (615) 751-8004 • Fax: (615) 751-0306

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TFS Kennedy Clinic
For Adults with Special Needs

FACE SHEET:

PATIENT INFORMATION		MEDICAL HISTORY
Patient First Name:	Patient Middle Name:	Patient Last Name:
Patient Social Security Number:	Patient Date of Birth:	Patient Gender:
Patient Street Address:	Patient City:	Patient County:
Patient State:	Patient Zip Code:	Patient Race:
Guardian Name: Guardian Address: Guardian Relationship to Patient: Guardian Phone: Guardian Email:	Primary Insurance Company: Primary Insurance Identification Number: Primary Insurance Group Number: Primary Insurance Policy Name: Primary Insurance Phone Number:	Secondary Insurance Company: Secondary Insurance Identification Number: Secondary Insurance Group Number: Secondary Insurance Policy Name: Secondary Insurance Phone Number:
Who should the clinic contact in order to confirm appointments? Contact Name: Contact Email: Contact Phone:	Case Manager Name: Case Manager Address: Case Manager Phone: Case Manager Cell Phone:	Next of Kin Name: Next of Kin Address: Next of Kin Relationship to Patient: Next of Kin Phone:
How did you find out about the TFS Kennedy Clinic?	Pharmacy Name and Phone?	Next of Kin Email:
In what setting does the patient live? ☐ With Family ☐ AFC ☐ Staffed Residence ☐ ICF/ID ☐ Independently ☐ Other:	Do you require the services of a translator? ☐ No ☐ Sign Language ☐ Spanish ☐ Other: Employment Status? ☐ Student ☐ Unemployed ☐ Full-Time ☐ Retired ☐ Part-Time ☐ Other	Day Program Name: Day Program Address: Day Program Phone:
Is the patient his or her own guardian? ☐ Yes ☐ No, **please attach conservatorship papers**	Does the patient have a living will or a do not resuscitate (DNR) order? ☐ No ☐ Yes, please attach	Does the patient have a valid Tennessee Power of Attorney? ☐ Yes, please attach
Who is your current Primary Care Physician?		

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MEDICAL INFORMATION

PAST MEDICAL HISTORY (Attach Additional Information if Necessary)
Please list all known current and prior illnesses (aside from minor injuries or infections).
Does the patient have intellectual disability? ☐ No ☐ Yes: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
Does the patient have any of the following conditions? ☐ Autism ☐ Cerebral Palsy ☐ Down syndrome ☐ Fetal alcohol syndrome ☐ Fragile X syndrome Any other known syndrome, please list or describe: Has the patient had genetic testing? ☐ No ☐ Yes, please state approximately how long ago:
Documentation of an ID/DD provided and attached? ☐ No ☐ Yes

Please list all hospitalizations with date, location and reason for stay.		
Date:	Location:	Reason for Stay:

Please list all past surgeries with date, location, reason for surgery and what was done.			
Date:	Location:	Reason for Surgery:	What was Done:

Please list any major injuries, accidents, or traumatic events you have experienced in your life.

FAMILY HISTORY		
Please tell us about any illnesses that run in the patient's family, include the relationship to the patient and age they were diagnosed.		
Relationship	Illness	Age at which relative was diagnosed

Please tell us about any family members with birth defects, genetic disorders or intellectual or developmental disabilities.

SOCIAL HISTORY

Does the patient smoke?	☐ No ☐ Yes, if yes, how much and how often?
Does the patient chew tobacco?	☐ No ☐ Yes, if yes, how much and how often?
Does the patient chew nicotine gum?	☐ No ☐ Yes, if yes, how much and how often?
Does the patient use e-cigarettes?	☐ No ☐ Yes, if yes, how much and how often?
Does the patient drink alcohol?	☐ No ☐ Yes, if yes, how much and how often?
Does the patient drink caffeinated beverages?	☐ No ☐ Yes, if yes, how much and how often?
Does the patient use any street drugs?	☐ No ☐ Yes, if yes, how much and how often?
Has the patient ever been addicted to any substances, including prescriptions?	☐ No ☐ Yes, if yes, please describe.
Is the patient currently sexually active?	☐ No ☐ Yes

☐ ☐ ☐

ALLERGIES

Is the patient allergic to any of the following: Medications ☐ No ☐ Yes Latex ☐ No ☐ Yes Seasonal Allergies ☐ No ☐ Yes Food ☐ No ☐ Yes Insect bites or stings ☐ No ☐ Yes	Please list what the patient is allergic to and what happens if he or she is exposed to it:

MEDICATIONS (Attach Additional Information if Necessary, Please Include Date Started)

Please list any medications the patient is taking and please include the name, dose and frequency of administration of the medication.

Medication Name	Dose	Frequency	Reason	Medication Name	Dose	Frequency	Reason

If necessary, please attach a list of additional medications to this form.

ASSISTIVE/IMPLANTED DEVICES

☐ G-tube	☐ Walker	☐ Glasses or contacts	☐ Spinal rod	☐ Communication device
☐ J-Tube	☐ Crutches	☐ Hearing aid	☐ Pacemaker	☐ Removable prosthetic
☐ Colostomy	☐ Wheelchair	☐ Inhaler	☐ C-PAP machine	☐ Vagus Nerve Stimulator

		FOR OFFICIAL USE ONLY
Signature	Date	Clinician Signature and Date
Print name of person signing above and relationship to the patient	Date	

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CONSENTS AND NOTIFICATIONS

Patient Name: _____ **Patient Date of Birth:** _____

Consent for Examination, Evaluation and Treatment

Consent. On behalf of the above-named patient, I hereby give my permission for the TFS Kennedy Clinic clinicians, or any clinician designated by the TFS Kennedy Clinic to perform medical or any other health related procedures offered by the clinic including, but not limited to: examination, diagnostic procedures such as photographic and video- based procedures, x-rays, laboratory testing, treatment and/or therapies.

I understand that examination or treatment of any patient embodies some level of risk for injury, up to and including death. I also understand that examination and treatment of a patient with intellectual and/or developmental disability (IDD) involves additional risks unique to this patient population. I also understand that there are risks associated with not examining and/or not treating problems identified by TFS Kennedy Clinic clinicians.

I understand that no outcome can be absolutely predicted or guaranteed as a result of treatment received, and I affirm that the TFS Kennedy Clinic has made no such prediction or guarantee.

Use of Anesthesia / Prescription Medication. I understand that some procedures done in the clinic requiring the use of anesthesia will involve local anesthesia. I understand that, should a referral to a hospital program, or should the utilization of IV sedation or general anesthesia be required to safely examine and treat, I will be informed and involved in the decision-making process.

I understand that the use of local anesthesia, or any medication that the clinician may prescribe, carries with it some inherent risks including, but not limited to previously undiagnosed drug allergy. I also understand that there are risks associated with not utilizing local anesthesia or other prescription medications.

I understand that, during the course of my treatment, certain controlled substances (medications) may be prescribed, and that the risks associated with the use of these types of medications may include but not be limited to nausea, vomiting, drug allergy, drug tolerance, and drug dependence.

Emergency Treatment. In case of emergency situations including but not limited to fractures of teeth / bones, acute infections, respiratory distress, or situations in which the clinician deems that severe pain or patient harm is either present or imminent, I give my permission for the clinician to provide the limited emergency treatment he / she deems appropriate to resolve the emergency situation.

Authorization to Film and Photograph

I hereby give permission for the TFS Kennedy Clinic to photograph or take videos of the above-named patient. I understand that these images will be used only for teaching purposes or for educational, informative or promotional materials that are intended to improve the quality of health care available to people with intellectual disabilities or developmental disabilities. I understand that under no circumstances will these photographs be sold to a third party. I also understand that the name of the above-named patient will not be revealed in any public forum outside the clinic facility without permission.

Consent to Utilize Medical Immobilization

General Consent. I hereby give my permission for any TFS Kennedy Clinic clinician, or any clinician he / she may designate, to utilize temporary medical immobilization (mouth prop, wrist wraps or papoose) during the delivery of services to the above-named patient, should the clinician deem it necessary for the safe delivery of care.

Associated Risks. I understand that the use of temporary medical immobilization embodies some level of risk for possible injury to the above-named patient. However, I also understand that there are risks associated with not using medical immobilization (e.g. risk of self-injury, etc.).

Medical Immobilization Policy. Our primary responsibility to our patients is to provide quality medical healthcare services in a safe environment.

Living up to this responsibility requires vigilance in areas that include: that instruments are sterile, that equipment is clean, and that the clinic is properly maintained. Safe and vigilant care also includes conducting an examination, developing an accurate diagnosis, and writing an individualized treatment plan. Equally important is our responsibility to protect our patients with intellectual disabilities from self- injury during the delivery of care. A basic creed, adhered to by all clinicians is “Do no harm.”

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Patients who either lack the ability to control their body movements or lack sufficient cognitive functioning to understand that their body movements may interfere with the performance of a procedure and in so doing may cause injury to themselves should have their movements managed in such a way as to prevent that self-injury.

In situations where the clinician determines that self-injury is likely, he or she, as the professional charged with that patient's well-being, *must* live up to his or her responsibility to provide for the patient's safety. The patient has a fundamental right to this level of safety.

The level of medical immobilization employed should be the least restrictive, effective method necessary to safely deliver care. Though, it is important to note that what constitutes the least restrictive, effective method may change based on the clinical judgment of the clinician. The *Clinic Hierarchy of Medical Immobilization Intervention* describes, from most passive to most aggressive, what those levels of intervention involve.

Clinic Hierarchy of Medical Immobilization Intervention:

1) Gentle hand holding / re-directing of hand movements
2) Mouth prop to limit mouth movement
3) Wrist wrap to limit upper limb movement
4) Papoose wrap to limit body movement
5) Oral sedation
6) IV sedation
7) Referral to the operating room for general anesthesia and endotracheal intubation.

The following section, *The Patient's Right to Freedom of Movement* addresses the clinician's legal considerations; and *The Patient's Right to Safety* discusses the medical considerations the clinician faces when deciding whether or not to employ medical immobilization.

The Patient's Right to Freedom of Movement. All patients served by the TFS Kennedy Clinic have a fundamental right to human dignity and privacy. Freedom of movement is an important part of both dignity and privacy. Many of the patients seen at the TFS Kennedy Clinic have had a person other than themselves designated by the Court as being their legal representative.

When obtaining consent to utilize medical immobilization, the TFS Kennedy Clinic provides the patient's legal representative with an opportunity to ask questions about medical immobilization and to have his or her questions answered in language he or she understands.

The Patient's Right to Safety. Many patients can be safely examined and treated in the clinic with no medical immobilization intervention being required. As has been stated, utilization of medical immobilization is sometimes indicated in an effort to promote the safe delivery of care.

However, in cases where the patient is severely resistant to examination and treatment, the clinician may determine that further attempts to examine, treat, or to utilize medical immobilization is unsafe; and that the process itself represents a risk of injury to the patient. These cases will be referred for treatment in the operating room under general anesthesia and endotracheal intubation.

The use of medical immobilization is one of many issues constantly being evaluated when delivering care to patients. Decisions regarding patient positioning, positioning of the chair, or use of a mouth prop are, in many ways, related to improving patient safety and comfort. It is critical that these decisions remain very *patient*-centered, and that they remain subject to revision, as clinical realities evolve and change.

Notification: What You Should Know About HIV and AIDS

AIDS is Acquired Immune Deficiency Syndrome- a serious illness which makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infections this person becomes ill. Most people with AIDS will die as a result of their infection. AIDS is caused by a virus called Human Immunodeficiency Virus, or HIV. Early diagnosis of HIV infection is important! If you have been told you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help you determine the best treatment for you. Free anonymous and confidential testing and counseling is available at every health department in Tennessee. After being infected with HIV, it takes between two weeks and six months before the test can detect the antibodies to the virus.

HIV Can Be Spread By:

1) Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, semen or cervical/vaginal secretions are exchanged
2) Sharing a syringe/needle with someone who is infected
3) Receiving contaminated blood or blood products (very unlikely now because blood used in transfusions has been tested for HIV antibodies since March 1985)
4) An infected mother passing HIV to her unborn child before or during childbirth, and through breast feeding
5) Receipt of transplant or infected tissue/organs or artificial insemination from an infected donor
6) A needle stick or sharps injury in a health care setting involving an infected person

You Cannot Get HIV Through Casual Contact Such As:

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1) Sharing food, utensils, or plates

2) Touching someone who is infected with HIV

3) Hugging or shaking hands

4) Donating blood (this has never been a risk for contracting HIV)

5) Using public rest rooms

6) Being bitten by mosquitoes or any other insect

Prevention:

1) Do not share needles or syringes with anyone

2) Do not have sexual intercourse except with a monogamous partner whom you know is not infected. If you choose to have sex with anyone else, use latex condoms (rubbers), female condoms or dental dams every time you have sex

3) Educate yourself and others about HIV infection and AIDS.

You Should Be Tested If You:

1) Have had sex with someone who has HIV

2) Have had sex with someone who has or has had any sexually transmitted disease (STD)

3) Have shared needles with or syringes with someone who has HIV

4) Have had multiple sex partners or you have had sex with someone who has had multiple partners

5) Have had sex through prostitution (male or female)

6) Have had sex with injecting drug users

7) Had a blood transfusion between 1978 and 1985

8) Are a woman who is pregnant or desires to be pregnant and who wishes to reduce the chance of your baby getting HIV from you should you be infected

How to Use a Latex Condom:

1) Use a new latex condom every time you have sex.

2) The condom should be rolled onto the erect (hard) penis, pinching ½ inch at the tip of the condom to hold the ejaculation (semen) fluid. Air bubbles should be smoothed out.

3) Use plenty of Water-Based lubricants such as K-Y Jelly, including a drop or two inside the condom, before and during intercourse. Do Not Use oil-based lubricants such as petroleum jelly, mineral oil, Crisco, or cold cream.

4) After ejaculating, withdraw the penis holding the condom at the base so it will not slip off.

5) Throw away the used condom and wash hands.

If You Need More Information, Please Call:

Tennessee HIV/AIDS Education Program (502) 564-6539; (Voice/TTY) (502) 564-6539

Tennessee AIDS Hotline 1-(800)840-2865 or the National AIDS Hotline 1(800)342-AIDS

Your local health department's HIV/AIDS Coordinator

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 5/6/2019, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us, or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends, or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient's representative the same way we would treat you with respect to your health information.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

1) Prevent or control disease, injury or disability;
2) Report abuse or neglect;
3) Report reactions to medications or problems with products or devices;
4) Notify a person of a recall, repair, or replacement of products or devices;
5) Notify a person who may have been exposed to a disease or condition; or
6) Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Worker's Compensation. We may disclose your Personal Health Information (PHI) to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized or permitted by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Education. We may disclose your health information to others, with redactions as to all personal identifying information, for the purposes of training, education, quality assurance/improvement, and other such related activities.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints **If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.**

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Joannie Bryant
Clinic Manager
831 Seven Oaks Blvd
Smyrna, TN 37167
Phone: (615)751-8004 Phone
(615)751-0306 Fax
Email: clinicmanager@tfskennedyclinic.org

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the practice's Privacy Official/Administrative Director at 831 Seven Oaks Blvd, Smyrna, TN, 37167. If I revoke this authorization, my revocation will not affect any actions taken by the practice before receiving my written revocation.
I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the following event occurs: _____

Authorization for Use and/or Disclosure of Patient Health Information

I hereby authorize the use and disclosure of the patient information as described in the *Notice of Privacy Practices*. I understand that

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information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. In addition, you may authorize, below, specific individuals to whom PHI may be released. If necessary, please list other recipients on the back of this form.

Name: _____

Relationship: _____

Type of Information to be released:

☐ Diagnosis ☐ Plan of Care

☐ Payment ☐ Other:

Name: _____

Relationship: _____

Type of Information to be released:

☐ Diagnosis ☐ Plan of Care

☐ Payment ☐ Other:

Name: _____

Relationship: _____

Type of Information to be released:

☐ Diagnosis ☐ Plan of Care

☐ Payment ☐ Other:

Name: _____

Relationship: _____

Type of Information to be released:

☐ Diagnosis ☐ Plan of Care

☐ Payment ☐ Other:

Confirmations and Signatures

Patient Name: _____

Patient Date of Birth: _____

I attest that the information provided in the above-named patient's MEDICAL INFORMATION is true and complete to the best of my knowledge. I understand and agree that the information I am providing will be relied upon by the TFS Kennedy Clinic. I affirm that I have received and read the *Consent for Examination, Evaluation and Treatment*, the *Authorization to Film and Photograph*, the *Consent to Utilize Medical Immobilization*, *Notification: What You Should Know about HIV and AIDS*, and the *Notice of Privacy Practices*.

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TFS Kennedy Clinic
For Adults with Special Needs

Please check your consent for the following:

☐Yes ☐No I give my consent to the TFS Kennedy Clinic to examine, evaluate and treat the above-named patient.

☐Yes ☐No I give my consent to the TFS Kennedy Clinic to film and/or photograph the above-named patient.

☐Yes ☐No I give my consent to the TFS Kennedy Clinic to utilize medical immobilization as described above.

☐Yes ☐No I give my consent to the TFS Kennedy Clinic to obtain, use and share the personal health information of the above-named patient.

☐Yes ☐No I give my consent to the TFS Kennedy Clinic to obtain the personal health information of the above-named patient from other treating healthcare providers.

☐Yes ☐No I give my consent to the TFS Kennedy Clinic to submit claims to and receive payment from the insurance carrier of the above-named patient for all professional services received.

_____ _____

Signature of Patient's Legal Representative Date

_____ _____

Name of Patient's Legal Representative (Please Print) Relationship to the Patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify):

REVIEWED BY:

_____

Signature and Date

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PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION

TO: _____

_____

_____

_____

The following applies to the Health Insurance Portability and Accountability Act Privacy Regulations pursuant to 45 CFR §164.5

The above-named provider is hereby authorized to release to **TFS KENNEDY CLINIC**, or any of its representatives, all medical, mental health, and dental records including all diagnostic testing and HIV-related records, concerning any medical treatment that the patient named below has received from you or at your institution. A photostatic copy hereof shall be as valid as the original authorization.

The following applies to disclosure of alcohol or drug services whose confidentiality is protected by Federal Law 42 U.S.C. §§ 290dd-22.

The above named provider is hereby authorized to release to **TFS KENNEDY CLINIC**, or any of its representatives, all medical, mental health, and dental records including all diagnostic testing and HIV-related records relating to any treatment or services that the patient named below may have received from you or at your institution related to alcohol and/or drug/chemical dependency. A photostatic copy hereof shall be as valid as the original authorization.

The purpose of this Authorization and request is to obtain medical, mental health or dental records which may be relevant as it pertains to the medical evaluation and/or treatment of the patient named below. The requested information is the minimum information needed in connection with the evaluation and/or treatment of the patient. I have the right to revoke this Authorization in writing by providing a signed, written notice of revocation to you and **TFS KENNEDY CLINIC**.

The above-named provider may not condition treatment or payment on whether this Authorization is executed. The information disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act. Any revocation of the Authorization is not effective with respect to actions a covered entity took in reliance on a valid Authorization and therefore, shall not apply to records produced by a covered entity prior to revocation. This Authorization is effective for two (2) years from the date of signing.

PATIENT NAME: _____ SIGNATURE: _____

SOCIAL SECURITY NUMBER: _____ PRINTED NAME: _____

DATE OF BIRTH: LEGAL RELATIONSHIP TO PATIENT:

_____ _____

SIGNATURE: PRINTED NAME:

_____ _____

TFS Kennedy Clinic
For Adults with Special Needs

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 5/6/2019 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us, or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends, or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient's representative the same way we would treat you with respect to your health information.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

1) Prevent or control disease, injury or disability;
2) Report abuse or neglect;
3) Report reactions to medications or problems with products or devices;
4) Notify a person of a recall, repair, or replacement of products or devices;
5) Notify a person who may have been exposed to a disease or condition; or
6) Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Worker's Compensation. We may disclose your Personal Health Information (PHI) to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized or permitted by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Education. We may disclose your health information to others, with redactions as to all personal identifying information, for the purposes of training, education, quality assurance/improvement, and other such related activities.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints **If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information**

or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Joannie Bryant
Clinic Manager
831 Seven Oaks Blvd
Smyrna, TN 37167
Phone: (615)751-8004 Phone
(615)751-0306 Fax
Email: clinicmanager@tfskennedyclinic.org

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the practice's Privacy Official/Administrative Director at 831 Seven Oaks Blvd, Smyrna, TN, 37167. If I revoke this authorization, my revocation will not affect any actions taken by the practice before receiving my written revocation.
I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Authorization for Use and/or Disclosure of Patient Health Information

I hereby authorize the use and disclosure of the patient information as described in the *Notice of Privacy Practices*. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. In addition, you may authorize, below, specific individuals to whom PHI may be released. If necessary, please list other recipients on the back of this form.

TFS Kennedy Clinic
For Adults with Special Needs

831 Seven Oaks Blvd * Smyrna, TN 37167
Phone: 615-751-8004 * Fax 615-751-0306

Primary Physician _____

Patient Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security Number: _____

DOB: _____ Employer: _____

Notice of Privacy Practices/Authorization for Treatment/Billing/Collection Policy

I understand that TFS Kennedy Clinic may share my health information for treatment, billing and healthcare operations. I have been given a copy of the practice's Notice of Privacy Practices that describes how my health information is used and shared and have had an opportunity to read and ask questions. I understand TFS Kennedy Clinic has the right to change this notice at any time. I may obtain a current copy by contacting the office or the Privacy Officer/Practice Manager.
I acknowledge that if I am 15 minutes late for my appointment that the appointment may need to be rescheduled. Scheduled appointment times are generally adhered to, but no guarantee is implied. Unforeseen events may cause rescheduling or cancellation of your appointment. I also understand that if I need to cancel or reschedule an appointment or procedure, I must contact the office at least 24 hours prior to the appointment.

Failure to follow physician's medical treatment or repeatedly missing appointments or procedures may result in the practice discontinuing medical care with TFS Kennedy Clinic.

Signature _____ Date _____

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

TFS Kennedy Clinic
For Adults with Special Needs

831 Seven Oaks Blvd

Smyrna, TN, 37167

Tel. 615-751-8004

Fax: 615-751-0306

Consent to Use Electronic Communications

First Name:_____

Last Name:_____

Address:_____

City:_____State:_____Zip:_____

Email (if applicable):_____

Phone (as required for Service(s):_____

The TFS Kennedy Clinic has offered to communicate using the following means of electronic communication ("the Services") [check all that apply]:

- Email
- Videoconferencing (including Kareo, Skype, FaceTime, Ring central, Zoom, Google Duo)
- Text messaging (including instant messaging)
- Website/Portal Social media (specify):
- Other (specify):

PATIENT ACKNOWLEDGMENT AND AGREEMENT: I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the TFS Kennedy Clinic. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the TFS Kennedy may impose on communications with patients using the Services. I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the TFS Kennedy Clinic using the Services may not be encrypted. Despite this, I agree to communicate with the TFS Kennedy Clinic using these Services with a full understanding of the risk. I acknowledge that either I or the TFS Kennedy Clinic, at any time,

withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered. I have reviewed and understand all of the risks, conditions, and instructions described in this Appendix.

Patient Signature_____

Date_____

Risks of using electronic communication:

The TFS Kennedy Clinic staff will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to use electronic communications). However, because of the risks outlined below, the TFS Kennedy Clinic cannot guarantee the security and confidentiality of electronic communications:

• Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.

• Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.

• Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.

• Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.

• Electronic communications can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the Physician or the patient.

• Even after the sender and recipient have deleted copies of electronic communications, backup copies may exist on a computer system.

• Electronic communications may be disclosed in accordance with a duty to report or a court order.

• Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

If the email or text is used as an e-communication tool, the following are additional risks:

• Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.

• Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

Conditions of using the Services:

• While the TFS Kennedy Clinic will attempt to review and respond in a timely fashion to your electronic communication, the TFS Kennedy Clinic cannot guarantee that all electronic communications will be

reviewed and responded to within any specific period of time The Services will not be used for medical emergencies or other time sensitive matters.

• If your electronic communication requires or invites a response from the TFS Kennedy Clinic and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.

• Electronic communication is not an appropriate substitute for in person or over the telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.

• Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.

• The TFS Kennedy Clinic may forward electronic communications to staff and those involved in the delivery and administration of your care. The TFS Kennedy Clinic might use one or more of the Services to communicate with those involved in your care. The TFS Kennedy Clinic will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.

• You agree to inform the TFS Kennedy Clinic of any types of information you do not want sent via the Services, in addition to those set out above you can add to or modify the above list at any time by notifying the Physician in writing.

•Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.

• The TFS Kennedy Clinic is not responsible for information loss due to technical failures associated with your software or internet service provider.

• You and TFS Kennedy Clinic will not use the Services to communicate sensitive medical information about matters specified below [check all that apply]:

- o Sexually transmitted disease
- o AIDS/HIV
- o Mental health
- o Developmental disability
- o Substance abuse
- o Other(specify)

TFS Kennedy Clinic
For Adults with Special Needs

831 Seven Oaks Boulevard
Smyrna, TN 37167-6485
Phone: 615-751-8004
Fax: 615-751-0306

RIGHTS OF PERSONS SERVED

POLICY

It shall be the policy of the Tennessee Family Solutions Inc. ("TFS") to comply with all applicable state and federal statutes and regulations regarding rights of persons who have developmental disabilities. The TFS Specialty Clinics shall implement this policy with the philosophy that civil rights are a human entitlement and that the TFS Specialty Clinics shall be a facilitator of that entitlement. Specifically, those rights we cherish are those critical to successful community living: respect, self-determination, freedom to associate and choices in daily living.

IMPLEMENTATION

The following Patient Rights are not subject to modification

All patients will be fully informed before or upon their admission about their rights and responsibilities and about any information on these rights imposed by the rules of the TFS Specialty Clinics. The information regarding patients' rights that is provided to the patient will include, at a minimum, the following:

- **Informed Rights:** All patients will be afforded rights to privacy, confidentiality and dignity. Any abridgement of these fundamental rights shall be done with the informed consent of the patient and/or their medical decision maker. In addition to the rights set out below, which are guaranteed by the regulations of the State of Tennessee, Department of Mental Health and Substance Abuse Services, these rights specifically include:

    1. The right to receive habilitation; to receive services from the provider of one's choice, to receive active treatment; to manage one's own affairs; to have freedom from abuse, neglect, mistreatment, victimization, exploitation, or the use of unauthorized or misused restraints; to make choices regarding daily living; to freely communicate grievances and recommend policy changes; to

confidentiality pertaining to records; to have access to one's records at reasonable times; to grant or refuse informed consent; to be treated as a person of dignity and worth in all areas of life.

2. **Complaint and Grievance Procedure:** Every patient served in the TFS Specialty Clinics has the right to treatment with consideration, dignity and respect in an environment free of exploitation, neglect or abuse. Complaints and grievances should be reported to the TFS Incident Management Coordinator. The TFS IMC has forms for the documentation of such reporting and will investigate the matter. If complaints of a different nature are involved the TFS IMC will direct the patient to an internal or external entity capable of addressing the issue.

3. **Advocacy Services:** Patients may choose to pursue outside advocacy assistance if TFS is unable to assist;
   1. Patient Advocate Foundation: www.patientadvocate.org
   2. National Patient Advocate Foundation: www.npaf.org
   3. National Health Council: www.nationalhealthcouncil.org
   4. The Patient's Association: 0800-345-7115
   5. Adult Protective Services: Phone: 888-277-8366
   6. Local Ombudsman: 615-850-3918
   7. TDMHSAS Office of Licensure: 866-797-9470
   8. Department of Children's Services: 615-253-1400
   9. Tennessee Disability Law & Advocacy Center: 615-298-1080
   10. Murfreesboro Office on Aging: 615-360-9797
   11. Volunteer Behavioral Health: 615-904-7051
   12. TFS Kennedy Specialty Clinic: 615-751-8004
   13. Trustpoint Mental Health Hospital: 615-716-1824
   14. Mobile Crisis: 615-726-0125
   15. Local Food Bank (2nd Harvest): 615-329-3491
   16. Medical Transport: 800-503-6897
   17. VA Medical Center (Alvin York): 615-867-6000

4. **General rules for patients are covered in the Admission TFS Clinic Patient Packet:** See copy of Patient Packet included in the *TFS Clinic Book*.

5. **If a patient fails to comprehend their rights:** If the patient and his or her conservator fail to initially grasp the meaning of the rights being represented to them, an effort will be made to assign an advocate capable to working through the issue with them. This advocate will not be an employee of TFS Kennedy Specialty Clinic. If the patient and his or her conservator are likely to continue indefinitely to be unable to understand this information, the TFS Specialty Clinic will promptly attempt to provide the required information to another parent, guardian, or appropriate person or agency responsible for protecting the rights of the patient.

- **Patients have** the right to voice grievances to staff of the TFS Specialty Clinic, to the TN Department of Mental Health and to outside representatives of their choice with freedom from restraint, interference, coercion, discrimination or reprisal;

- **Patients have** the right to be treated with consideration, respect and full recognition of their dignity and individuality;

- **Patients have** the right to be protected by the TFS Specialty Clinics from neglect, from physical, verbal and emotional abuse (including corporal punishment); and from all forms of misappropriation and/or exploitation;

- **Patients have** the right to be assisted by the TFS Specialty Clinics in the exercise of their civil rights;

- **Patients have** the right to be free of any requirement by the TFS Specialty Clinics that they perform services which are ordinarily performed by Clinic staff;

- **Patients have** the rights, if TFS should be providing overnight treatment, to send personal mail unopened and to receive mail packages which may be opened in the presence of staff when there is reason to believe that the contents thereof may be harmful to the patient or others;

- **Patients have** the right to privacy while receiving services from the TFS Specialty Clinics;

- **Patients have** the right to have their personal information kept confidential in accordance with state and federal confidentiality laws; *see HIPAA policies contained in The Clinic Book;*

- **Patients have** the right to ask the TFS Specialty Clinics to correct information in their records. If the TFS Specialty Clinic refuses, the patient may include a written statement in the records of the reasons they disagree;

- **Patients have** the right to be informed about their care in a language they understand; and

- **Patients have** the right to vote, make contracts, buy or sell real estate or personal property, or sign documents, unless the law or a court removes these rights. In such an instance the legal representative or conservator shall possess the right to exercise these rights in the patient's behalf as permitted by law.

The following Patient Rights are only subject to modification with specific requirements set out in regulations of the State of Tennessee, Department of Mental Health and Substance Abuse Services.

- **Patients have** the right to participate in the development of the patient's individual program or treatment plans and to receive sufficient information about proposed and alternative interventions and program goals to enable them to participate effectively;

- **Patients have** the right to participate fully, or to refuse to participate, in community activities including cultural, educational, religious, community services, vocational and recreational activities;

- **If overnight** services are provided a patient, he/she must be allowed to have free use of common areas in the TFS Specialty Psychiatric Clinic facility with due regard for privacy, personal possessions, and the rights of others;

- **Patients have** the right to be accorded privacy and freedom for the use of bathrooms when needed;

- **Patients shall** be permitted to retain and use personal clothing and appropriate possessions including books, pictures, games, toys, radios, arts and crafts materials, religious articles, toiletries, jewelry and letters;

- **Patients being** treated overnight in the TFS Specialty Clinic facilities; if married, shall be afforded privacy for visits by spouses and if both spouses are residing at the same time, they must be permitted to share a room;

- **Patients being** treated overnight in the TFS Specialty Psychiatric Clinic facilities have the right to associate and communicate privately with persons of their choice including receiving visitors at reasonable hours; and

- **Patients being** treated overnight in the TFS Specialty Psychiatric Clinic facilities have the right to be given privacy and freedom in the use of their bedroom/sleeping area.

Filename: Patient Rights.doc (MSWORD 2013)
Previous Revisions: N/A
Latest Revision: June 1, 2020
Approval Date by the TFS Board of Directors: June 1, 2020

CEO's Signature

TFS Kennedy Clinic
For Adults with Special Needs

831 Seven Oaks
Boulevard
Smyrna, TN 37167-6485
Phone: 615-751-8004
Fax: 615-751-0306

- **I _____, hereby acknowledge that I have received a copy of the *"TFS Clinic Rights of Persons Served";***
- **I understand that any questions I might have concerning this policy should be directed to TFS Clinic staff for answers;**
- **I understand that I have the right of grievance in the event I believe that my patient rights have been violated;**
- **I understand that I am entitled to seek out an advocate to act on my behalf and acknowledge the receipt of a list of advocates;**
- **I authorize clinical services to be rendered via telehealth to the service recipient. These services will be in compliance with HIPAA requirements.**
- **The TFS Clinic practitioner will make every reasonable effort to maintain the service recipient's privacy and confidentiality.**

_____ _____
Signature of Individual **Date**

_____ _____
Signature of Legal Guardian/Parent/Conservator **Date**

_____ _____
Signature of Witness/Title **Date**

TFS Kennedy Clinic
For Adults with Special Needs

Flu Shot Consent Form

Name: _____ Date: _____

Date of Birth: _____

Allergies:

_____

Consent for Flu Shot: Yes _____ No: _____

Conservator Name: _____

Conservator Signature: _____