Rebound Mental Health
6202 South Lewis Avenue, Suite A
Tulsa, OK 74136
(918)949-4515 P (918)949-4523 F

PATIENT REGISTRATION FORM

Patient Information

Patient's Last Name	First	MI	☐ single ☐ married ☐ divorced ☐ widowed	Sex

Street Address	City	State	Zip

Phone #1	☐ work ☐ home ☐ mobile ☐ other	Phone #2	☐ work ☐ home ☐ mobile ☐ other
( )		( )	

DOB (*mm/dd/yy*)	Social Security #	E-mail Address (For reminder calls and communication)	Sign here if you would like email appointment reminders

Employer	Employer's Address	Employer Phone
		( )

Patient's Primary Care Physician	Physician Phone
	( )

Parent/Guarantor Information

Parent or Guarantor	DOB (*mm/dd/yy*)	Home Phone #	Mobile Phone #
		( )	( )

Address	City	State	Zip

Insurance /EAP Information

Last Name of Insured (Policy Holder)	First Name of Insured	Social Security #	DOB (*mm/dd/yy*)

Insured's Address	City	State	Zip

Insured's Place of Employment	Phone Number	Insured's Email Address
	( )	

Name of Insurance	Name of EAP	Number of Sessions	Customer Service #	Member ID #	Group #	Copay/Coins.

For Children Under the Age of 18

If legal custody is shared, has permission been granted for treatment?	☐ Yes	☐ No
To whom may we release information?		

Emergency Contact (other than patient or guarantor)

Contact Name	Relationship to Patient	Home Phone #	Mobile Phone #
		( )	( )

The above information is accurate and correct to the best of my knowledge. By signing, I consent to treatment for the above named patient.

Patient/Guardian Signature:		Date:	

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I have been informed of, have read the information contained in the Appointment Policy, Financial Policy, and HIPAA Notice of Privacy Policy

Patient Name (print) _____

Patient Signature (if over 18 years) _____

Guarantor for Payment (print) _____

Relationship to Patient (circle one) self parent/guardian other

Guarantor Signature_____

Date _____ / _____ / _____

CREDIT CARD INFORMATION (Optional)

I agree to keep my correct and updated credit card information on file to be used for missed appointments, records, letters, and/or outstanding balances. This information is for internal use only and will not be distributed to third parties.

(Circle one) MasterCard or Visa

Credit Card Number _____-_____-_____-_____

Expiration date _____ /_____ CVC Code _____ Zip code _____

Name as it Appears on Card _____

Signature _____

Rebound Mental Health, LLC

When completing counseling services, continuity is vital to success. Frequent cancellations or failing to schedule appointments can lead to delays between therapy sessions that may impede progress. As a mental health service provider, I try to assist in finding suitable times for us to meet for sessions. Our success is a joint effort: therefore your cooperation in keeping appointments is critical to your success. I would like to outline for you the attendance policy for **Rebound Mental Health, LLC, 6202 S. Lewis Suite A. Tulsa, Ok 74136.**

1. To schedule appointments, please call 918-949-4515

2. We require a minimum of 24 hours' notice for changes or cancellations of appointments. If you do not cancel with a minimum of 24 hours, the patient is responsible for the fees accrued.

3. Please contact the clinic/therapist as soon as you are aware you need to cancel. (This is also within the minimum of 24 hours)

4. If you are late for an appointment, the appointment will still end at the scheduled time.

5. If you cancel or do not show up for two consecutive appointments, you will receive notice that your session time may be made available to other patients. In this case, call the clinic to schedule a time suitable for you. **RMH will reserve right to close your file. Two no-shows may result in end of duty of care.**

6. Office hours are Monday – Thursday 9:00 a.m. to 5:00 p.m. by appointment only.

Contact Information

(918) 949-4515 phone
(918) 949-4523 fax

cshort@reboundmh.org
spyle@reboundmh.org
mfox@reboundmh.org
tbosley@reboundmh.org
cjhughes@reboundmh.org
aramsey@reboundmh.org

We look forward to working with you.

Financial Policy

REBOUND MENTAL HEALTH, LLC

Below are the terms of agreement regarding payment for sessions at Rebound Mental Health, LLC.

1. Session fees are based on a clinical hour, which is defined by insurance providers as 45 minutes direct with the counselor or professional.

2. If, I the patient fail to appear for an appointment without 24-hour notice of cancellation, cancellation fees will be charged and I will be responsible for payment.

3. I understand that if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.

4. Services including phone calls, emails, record reviews and professional consults at times other that the scheduled therapy session will be the patient's responsibility. These services will be billed per quarter of an hour.

5. I authorize my health insurance to provide payment of benefits to Rebound Mental Health LLC.

6. I understand records of my treatment may be shared with my insurance company when necessary to process claims.

7. I understand I am responsible for payment if my insurance company declines payment.

8. Under the circumstances that Rebound Mental Health does not accept your health insurance policy, Rebound Mental Health will supply a receipt of payment for services. You can submit this receipt to your insurance company for reimbursement.

9. Payment must be made by check, cash and/or credit. Your fee or co-pay is due at the time services are provided. The patient is responsible for all fees. This includes any fees denied by insurance providers. Fees must be paid within 30 days after the dated the claim is denied.

10. Returned checks will result in an additional service fee of $25.00

11. Rebound Mental Health reserves the right to utilize a collection agency to obtain unpaid balances.

12. Professional Fees:

Intake	$150.00
Session	$125.00

**** Prompt Payment Discount of 20% available for self-pay clients.**

Prompt Payment Discount Self-Pay	Intake	$120.00
Prompt Payment Discount Self-Pay	Session	$100.00

Late Cancellation Fees (Same day Cancellation) &	$25.00 Before 4 p.m.
No Show Fees	$50.00 After 4 p.m.

Telephone Consults
30 minutes $50.00

Correspondence

Single Page Letter	$25.00
Reports	$50.00 per hour
(schools, employers, professionals)	

13. **In cases where RMH is court ordered to provide services, client will be required to submit payment in advance of services rendered**.

Court retainer	$300.00

Court Fees

Travel/Wait time	$75.00 per hour
Consult/Testimony	$150.00 per hour
Review of Case File	$75.00 per hour

Rebound Mental Health HIPAA Notice of Privacy Policy

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at _____:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at _____ or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

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PATIENT REGISTRATION FORM- SUPERVISED VISITATION

Patient Information				
Patient's Last Name	**First**	**MI**	☐ single ☐ married ☐ divorced ☐ widowed	**Sex**

Street Address	**City**	**State**	**Zip**

Phone #1	☐ work ☐ home ☐ mobile ☐ other	**Phone #2**	☐ work ☐ home ☐ mobile ☐ other
( )		( )	

DOB (*mm/dd/yy*)	**Social Security #**	**E-mail Address**

Employer	**Employer's Address**	**Employer Phone**
		( )

Patient's Primary Care Physician	**Physician Phone**
	( )

By signing this consent I also agree for limited information, if necessary, to be shared with the above named clinician in order to facilitate my/my child's evaluation/treatment.

Patient/Guardian Signature:		**Date:**	

Emergency Contact (other than patient or guarantor)			
Contact Name	**Relationship to Patient**	**Home Phone #**	**Mobile Phone #**
		( )	( )

The above information is accurate and correct to the best of my knowledge.			
Patient/Guardian Signature:		**Date:**	

HOUSEHOLD INFORMATION:

Please list all children who will be participating in supervised visits or neutral exchanges:

CHILD #1

Name: _____ Gender: □ Female □ Male
Social Security Number: _____ Date of Birth: _____
Race or Ethnic Group: □ African American □ Asian □ Bi-racial □ Caucasian □ Hispanic □ Native American □ Other (please specify)

CHILD #2

Name: _____ Gender: □ Female □ Male
Social Security Number: _____ Date of Birth: _____
Race or Ethnic Group: □ African American □ Asian □ Bi-racial □ Caucasian □ Hispanic □ Native American □ Other (please specify)

CHILD #3

Name: _____ Gender: □ Female □ Male
Social Security Number: _____ Date of Birth: _____
Race or Ethnic Group: □ African American □ Asian □ Bi-racial □ Caucasian □ Hispanic □ Native American □ Other (please specify)

If needed, list additional children involved in supervised visitation or neutral exchanges on the back of this page.

REFERRAL INFO:

Referred by: ❑Court Ordered ❑Court Recommended ❑Mediation

❑Custodial Lawyer ❑Office of the Children's Lawyer ❑Non-Custodial Lawyer ❑Self-Referral

❑Other (specify) _____

Referral Date: _____

HEALTH INFORMATION:

Do you have any health or mental health illnesses/conditions/disabilities? □ Yes □ No

Diagnosis: _____

DOMESTIC VIOLENCE AND FAMILY VIOLENCE:

Is there a history of domestic or family violence between the parties? □ Yes □ No

Is there a history of stalking? □ Yes □ No

Is there a safety plan? □ Yes □ No

If yes to any of the above questions, please explain:

_____

_____

Was anyone ever formally charged with Domestic Violence? □ Yes □ No

What were the charges?_____

Is there a Civil Protection Order (TRO/TPO) in place? □ Yes □ No

If yes, describe reason for TRO/TPO: _____

_____

What County or City Court issued the TRO/TPO: _____

Has either party violated the TRO/TPO? □ Yes □ No **If yes, name of person:** _____

Has the CHILD(REN) witnessed or experienced family violence (hitting, pushing, screaming, yelling, verbal fights, etc.)? □ Yes □ No

If yes, describe: _____

_____

JAIL AND PRISON INFORMATION:

Are you on… probation or parole? If yes, for how long? PO Officer: _____

Have either party served any time in jail or prison? □ Yes □ No *If yes*, *Who*? _____

Describe what the offense was, the amount of time served, and where it was served:

_____

SUPERVISED VISITATION & THERAPEUTIC VISITATION GUIDELINES AND CONTRACT

Supervised Visitation and Therapeutic Visitation Services are available to assist parties and the Court in supervising interaction between adults and children and assuring the safety of the children. The guidelines set forth are not negotiable and if they are not followed will be grounds to terminate services at our center.

Please initial beside each section and sign the last page of the document.

SERVICES:
Supervised Visitation (SV) refers to contact between a non-custodial parent and one or more children in the presence of a supervisor. Therapeutic Visitation (TV) is supervised visitation by a licensed mental health professional with advanced training in childhood trauma combined with team consultation and recommendations for future visitation. Visitations are court ordered or recommended by the Department of Human Services in cases involving allegations of sexual, physical and emotional abuse of a child, domestic violence, kidnapping, substance abuse, or mental illness by the parent.

HOURS OF OPERATION:
Rebound Mental Health business hours are from 9:00 a.m. until 5:00 p.m. Monday through Thursday. We are closed on Independence Day, Thanksgiving Day, Christmas Eve, Christmas Day, New Year's Eve, and New Year's Day.

CANCELLATIONS & MISSED VISITATION/EXCHANGES:
The canceling party will incur the **full fee** of the visitation or exchange if they fail to notify the supervisor 24 hours prior to the visit. If the parties provide the center with written instructions signed by a physician and specifying that the visitation with the other party should not occur and the party notifies the center at least two hours in advance the parties will not be held responsible for the cost of visitation.

INTAKE:
Custodial party, visiting party, and child(ren) must complete the intake and orientation process. Each party must consent to the visitation guidelines.

Once all parties have completed the intake process and Rebound Mental Health is in receipt of the court order, scheduling letters will be faxed to the attorneys who are expected to confirm the appointment times with you. Visitation will attempt to comply with the hours specified by a court order; however the time and amount of hours for visitations for each family will be dependent on the availability of the resources. The supervisor may adjust the schedule at any time during services.

FEES:
Unless fees are specifically addressed in the court order, each party will be responsible for cost.

- Intake - **SV:** $50.00 per session. **TV:** $75.00 per session.
- Visitation Sessions - **SV:** $50.00 per/hr. **TV:** $75.00 per/hr**.** Prepaid for first 5 units.
- Team Consultation and Written Court Report - $350.00 per/hr. or Team Consultation with Medical Team and Written Court Report - $550.00 per/hr.
- Court - $150.00 per/ hr (testimony/consultation) $75.00 per/hr (travel/wait time)

HOW VISITATIONS OCCURS:

- The visiting party will arrive 15 minutes before the scheduled visitation time and wait in the waiting room. The custodial party and child(ren) will arrive at the designated visitation time and enter through the door marked "private entrance" which leads into the visitation room. The therapist will go get the visiting party and the custodial party will exit through the private door. The custodial party will walk down to the waiting room and wait there during the visit. Immediately following the visit, the visiting party will leave the Rebound Mental Health office and parking lot. The child will have a de-briefing with the supervising therapist. *(Subject to change on a case-by-case basis.)*

- If either party is 15 minutes late, the visitation will be cancelled and all parties will be notified of the cancellation.

- All visits are to remain in the room they are assigned during the entire visit unless the visiting party or child needs to use the restroom.

- Only adults and children authorized by the court agreement are allowed to discuss the case with staff, cancel appointments, schedule appointments, transport, exchange, or be present during visitation with the child; unless otherwise designated by intake therapist.

INTERACTION DURING THE EXCHANGES AND VISITATIONS:

- Children should be taken to the restroom prior to the visit. If the child needs to use the restroom or needs a diaper change during the visit, the child will be taken to the custodial party to use the restroom and promptly returned to the visitation.

- The visiting person is responsible for setting limits and managing the child's behavior. Physical discipline of any type is not allowed. Negative comments, talking down to the child(ren), and/or foul language will not be tolerated.

- The visiting person is expected to interact with the children in a positive and developmentally appropriate manner. Any communication or behavior that is emotionally or physically threatening to the child will not be allowed.

- Conversations between the visiting person and the child will focus on the child's interests and activities. Discussions should focus on the present to avoid pressure and disappointment. The visiting person will not question the child, discuss the other parent/guardian, the allegations of the case, or court hearings. The supervisor will guide the visiting person in providing appropriate answers to the child's questions, if needed.

- The visiting person will not be allowed to make any type of threat, bribe, promises, coercion and manipulation during the visit. This includes statements like "when this is over" and/or "when you live with me."

- **The use of cell phones, communication devices, and cameras are strictly prohibited during visits by the custodial or visiting party.**

- The conversations between the child and the visiting person must be in English and audible by the supervising therapist. If the visitation supervisor cannot speak and understand the language being spoken by the visiting party and the child, a neutral interpreter over the age of 18 must accompany them.

- Gifts and food are prohibited during the visitation. Children are encouraged to bring school report cards, trophies, and pictures of their activities to visitation.

- Arrangements regarding medications or any additional special needs must be made prior to the first visitation.

- The visiting person must avoid alcohol and controlled substances for 24 hours before visits with child(ren). The visit will not take place if you appear to be under the influence or drugs or alcohol.

- Weapons are not allowed at Rebound Mental Health facility.

- Concerns or discussions regarding the case from all parties should be addressed in writing to the supervising therapist.

- The supervisor has the right to end the session at any time if she/he deems that the child is acutely stressed, at risk of imminent harm either emotionally or physically, or the visiting parent is not following the program rules.

- After refusal of visitation by minor child, the supervising therapist will attempt to schedule a meeting with all parties to develop a strategic plan to resume visitations. This strategic plan will be formulated and agreed upon by all parties.

- Pursuant to Supervised Visitation Network policy, Rebound Mental Health will suspend visitations if criminal charges are filed against either party.

- The therapeutic supervisor will videotape therapeutic visitation sessions. Videotaped sessions will be used for consultation with other professionals involved in the case. Videotaped sessions are maintained at Rebound Mental Health as a part of case record.

- In cases involving **allegations of sex abuse** the following guidelines will also be followed. The parent and child will be taught **"Please Stop"** during the intake process. All parties will respect when the child says "Please Stop" and **immediately stop** the behavior or conversation that is making the child uncomfortable. The visiting person will **not be allowed to tickle, wrestle or forcible touch the child in any way.** The visiting person will **not have the child on their lap or engage in a frontal hug or kissing.** The visiting person will **not engage any activity or game that requires removing any clothing.** The visiting person will be able to offer the child a side-hug. **The child will be given the opportunity to refuse any type of physical touching.**

CONFIDENTIALITY

Rebound Mental Health will maintain confidentiality and refuse information without written permission, *except* in response to a subpoena request, in reports of suspected child abuse and neglect to the appropriate authority as required by law, and in reporting dangerousness or threats of harm to self or others as required by law.

ACKNOWLEDGMENT OF UNDERSTANDING OF SERVICES, RULES, AND GUIDELINES

The most important rule to remember is that all parties are expected to comply with directives of Rebound Mental Health staff while they are on site. The first priority of supervised visitation is to provide a safe environment for children.

I HAVE READ AND RECEIVED A COPY OF THESE RULES AND HAVE A COPY FOR MYSELF. I UNDERSTAND REBOUND MENTAL HEALTH RESERVES THE RIGHT TO REVISE AND/OR CHANGE POLICIES AT ANY TIME OR MODIFY RULES ON A CASE BY CASE BASIS. MY SIGNATURE BELOW INDICATES I UNDERSTAND THESE RULES AND AGREE TO FOLLOW THESE RULES. I UNDERSTAND THAT THE INFORMATION GATHERED DURING EXCHANGES AND SUPERVISED VISITATIONS WILL BE RELEASED TO THE COURT AND OTHERS AUTHORIZED BY THE COURT TO HAVE SUCH INFORMATION. I UNDERSTAND THAT IF I DO NOT COMPLY WITH THESE RULES, THE VISITATION OR EXCHANGES MAY BE SUSPENDED OR TERMINATED AND NOTICE OF SUCH MAY BE PROVIDED TO THE COURT.

_____ _____

Signature Date