Trustbridge Bereavement Center
Registration and Informed Consent

Informed Consent Statement

I, _____, am presenting myself to TrustBridge Bereavement Center for counseling services.
(Client Receiving Services)

CONSENT FOR SERVICES: I hereby voluntarily consent to and authorize such services, which may include (but are not necessarily limited to) individual support, group support, or education, by authorized agents and employees of the facility or their designees as may in their professional judgment be necessary and beneficial. I acknowledge that no guarantees have been made to me as to the effect of such assessments or services provided. I understand I may be provided with resources and referrals if additional support is required.

CONFIDENTIALITY: I understand that TrustBridge Bereavement Center clinicians maintain confidentiality of client information in accordance with the legal and ethical requirements of their profession. I accept that my information may be released or reported under certain circumstances that are required by law (see "Client Bill of Rights and Privacy Notice").

RESPONSIBILITY FOR PERSONAL VALUABLES: I hereby release TrustBridge Bereavement Center from any liability resulting from loss by theft or negligence of mine or that of any employee. I understand that I am fully responsible for all of my personal articles while at the TrustBridge Bereavement Center.

Services in this program are rendered without distinction to race, faith, national origin, handicapping condition, age, or sexual orientation. This program complies fully with: Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. I have been informed of my rights and have received a copy of the "Client Bill of Rights and Privacy Notice" (BER720).

By providing your e-mail address, you agree to Trustbridge Bereavement Center communicating with you and sending information related to Trustbridge bereavement programs. You may opt out of receiving such communications at any time by emailing bereavementevents@trustbridge.com.

The undersigned certifies that he/she has read the above paragraphs and is the client, or is duly authorized by the client as the client's general agent, to execute the above and accept its terms.

Demographic Information

First Name _____ Last Name _____

Primary Phone _____ Email Address _____

Information about the Loss

Date of Death _____ Relationship to Deceased _____

Cause of Death _____

Was your loved one a hospice patient? □ Yes, Trustbridge □ Yes, Another Hospice □ No

If Trustbridge, please provide the patient's name: _____

Date: _____ Client's Signature: _____

Office Location: ☐ Juno Beach ☐ Boca Raton Parent/Guardian Signature:_____

☐ West Palm Beach ☐ Fort Lauderdale Printed Name, Parent/Guardian:_____

☐ Boynton Beach ☐ Other _____

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Client Bill of Rights & Privacy Notice

DEFINITION: The Trustbridge Bereavement Center is a counseling/education program created to offer anyone experiencing concerns with grief and bereavement with the special support and guidance they may need to face the realities of loss and change.

As a client, you have the right to:

- Be treated with dignity, courtesy and respect.
- Be fully informed of all services available to you at **The Trustbridge Bereavement Center**
- Receive competent, individualized service from qualified **Trustbridge Bereavement Center** staff.
- Report abusive, neglectful or exploitative practice to Florida statewide toll-free telephone number, you may call toll free **1-800-96-ABUSE (1-800-962-2873)**
- Make informed and self-determined decisions about the service you receive.
- Receive information to help you make such decisions and to participate in developing and revising your Plan of Care.
- Receive prior notice and to make an informed decision before receiving clinical service from a Master's level graduate student or participating in any research projects.
- Voice grievances, opinions, recommendations, in relation to policies and services offered by **The Trustbridge Bereavement Center**, without fear of discrimination or reprisal.

If at any time you are dissatisfied with your care:
complaints, recommendations or grievances should be reported to:
Bereavement Manager at (561) 227-5175.
Trustbridge Bereavement Center
300 Northpoint Parkway, Suite 305, West Palm Beach, Florida 33407

I also understand I have a responsibility to:

- Provide accurate and complete information to **The Trustbridge Bereavement Center** regarding your medical, psychological, psychiatric and financial state.
- To provide accurate and updated information on other health care providers from whom you may receive treatment or care.
- Agree to accept staff providing services regardless of age, race, color, national origin, religion, sex, disability or any other category protected by law.
- Participate in planning, evaluating and revising my care plans to the degree that I am able to do so.
- Notify **The Trustbridge Bereavement Center** of the need to cancel or reschedule a scheduled visit a minimum of 24 hours in advance.

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Client Bill of Rights & Privacy Notice

Privacy Under the Health Insurance Portability and Accountability Act (HIPAA)

Trustbridge protects your medical information and your rights regarding your own medical records. We are dedicated to protecting your right to privacy of your medical information, while providing the highest quality medical care. We want you to be aware of regulations that affect how we use and disclose your medical information, and the rights you have regarding your medical records. Privacy rules adopted as part of the federal Health Insurance Portability and Accountability Act (HIPAA) establish standards for the release of medical information that personally identifies you.

Our Privacy Practices

We must provide you access to a privacy notice that explains how we may use or disclose your medical information. We will ask you to acknowledge that you have received and understand our privacy notice when you are first admitted.

Your Permission

Once we have informed you about our privacy practices, you may designate to whom you want your medical information released. We may then release information about you for purposes of your treatment, billing for services, or for Hospice operations such as quality assurance without further permission from you. You may revoke your permission to use and disclose your medical information at any time.

Authorization

You may be asked to sign an authorization form allowing release of information for other purposes not related to your treatment, billing for services or Hospice operations. However, you are not required to sign an authorization form. We will not deny treatment if you elect not to sign the authorization form.

Your Rights Regarding Medical Records

Federal privacy regulations give you many rights regarding your medical records, including:

- The right to an accounting of certain disclosures of your medical information. Medical records are retained for six years.
- The right to inspect and obtain a copy of your medical information.
- The right to receive confidential communications of your medical information by an alternative means or at an alternative location.
- The right to request an amendment to your medical record.
- The right to submit a complaint about how your medical information is used or disclosed.

If you have any questions about how we will use or disclose your medical information, please contact Health Information Management at (561) 227-5215.

For questions regarding your rights, or HIPAA, call our Compliance Hotline at 1 (800) 765-7408.

For additional rights and privacy information, please ask your counselor.