

INTAKE /ASSESSMENT FORM

Welcome! These forms will give you the chance to describe your situation and history. Please fill them out as completely as possible and have them ready before your first counseling session.

CLIENT INFORMATION

Name: _____

Date of Birth: _____ Race: _____ Age: _____ Female Male Non-binary

Address: _____

Occupation: _____ Employer: _____

School (if student): _____

Phone (h): _____ Messages ok at home? Yes No

Phone (cell): _____ Messages ok on cell? Yes No
(Note: I cannot guarantee the confidentiality of cell conversations.)

Phone (w): _____ Messages ok at work? Yes No

Email: _____ Emails ok? Yes No
(Note: I cannot guarantee the confidentiality of email.)

Website: _____

May I have your permission to look at your website? Yes No

How did you find out about my services? _____

If referred by a person, may I have your permission to thank him/her? Yes No

Religious Affiliation: _____

Ethnic/Cultural Heritage: _____

MARITAL STATUS

Single Married (legally) Divorced Total # of marriages: _____

Cohabiting Divorce in process Separated Widowed Other: _____

Assessment of current relationship (if applicable): Good Fair Poor

FAMILY INFORMATION

Relationship	Name	Age	Sex	Type(bio, step, etc.)	Living with you?
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Mother	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Father	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
--------	-------	-------	-------	-------	--

Spouse/SO	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
-----------	-------	-------	-------	-------	--

Children/	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Siblings

_____ Yes No

(Continue on back or extra page if needed)

EDUCATION

Fill in all that apply: Years of education: _____ Currently enrolled: Yes No

_____ High School grad/GED _____ College

_____ Vocational: _____ Graduate School Yes No

Other training: _____ Yes No

Special circumstances: _____ Yes No

MILITARY

Military experience? Yes No

Combat experience? Yes No

Where: _____

Branch: _____

Type of discharge: _____

Length of service: _____

Rank at discharge: _____

PERSONAL STRENGTHS

What do you do well and what activities do you enjoy? _____

What personal qualities would others say you have? _____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? Yes No

Approximate Dates of Counseling: _____

For what reason? _____

What did you find **most helpful** in therapy? _____

What did you find **least helpful** in therapy? _____

Have you used psychiatric services? Yes No Was it helpful? Yes No

Please describe. _____

Have you taken medication for a mental health concern? Yes No



Name of medication	Dates Taken	Helpful?(Y/N)

Do you have other medical concerns or previous hospitalizations? Please describe. _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past. _____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you/your adolescent desire to have counseling? _____

What would you like to see happen as a result of counseling? _____

What is most concerning right now? _____

CURRENT FAMILY AND SIGNIFICANT RELATIONSHIPS

Strengths/supports (relationships, support groups, etc.)

Stressors/problems

Recent changes

Changes desired

FAMILY CONCERNS

Please check any family concerns that you are having

- | | |
|---|--|
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Disagreeing about Relatives |
| <input type="checkbox"/> Feeling Distant | <input type="checkbox"/> Disagreeing about Friends |
| <input type="checkbox"/> Loss of fun | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> Lack of honesty | <input type="checkbox"/> Drug Use |
| <input type="checkbox"/> Physical fights | <input type="checkbox"/> Infidelity |
| <input type="checkbox"/> Education problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Money | <input type="checkbox"/> |

SUBSTANCE USE

Please check substances you use on a weekly/monthly (circle) basis:

Alcohol	_____ x per week / month	Meth	_____ x per week / month
Marijuana	_____ x per week / month	Ecstasy	_____ x per week / month
Cocaine	_____ x per week / month	Other	_____ x per week / month
Heroin	_____ x per week / month		

Check all that apply:

- _____ I believe that my substance use may be a problem.
- _____ I believe that my partner's substance use may be a problem.

INDIVIDUAL CONCERNS

Please check any personal concerns that you are having:

- | | |
|--|--|
| <input type="checkbox"/> Sadness _____ | <input type="checkbox"/> Grief/loss _____ |
| <input type="checkbox"/> Crying _____ | <input type="checkbox"/> Work issues _____ |
| <input type="checkbox"/> Irritability _____ | <input type="checkbox"/> Spirituality issues _____ |
| <input type="checkbox"/> Loss of pleasure _____ | <input type="checkbox"/> Alcohol Use _____ |
| <input type="checkbox"/> Sleep problems _____ | <input type="checkbox"/> Another's Alcohol Use _____ |
| <input type="checkbox"/> Eating problems _____ | <input type="checkbox"/> Drug Use _____ |
| <input type="checkbox"/> Hopelessness _____ | <input type="checkbox"/> Another's Drug Use _____ |
| <input type="checkbox"/> Guilt _____ | <input type="checkbox"/> Hurting Self _____ |
| <input type="checkbox"/> Mood swings _____ | <input type="checkbox"/> Hurting others _____ |
| <input type="checkbox"/> Fear _____ | <input type="checkbox"/> Anger/Rage _____ |
| <input type="checkbox"/> Nightmares _____ | <input type="checkbox"/> Abuse (childhood) _____ |
| <input type="checkbox"/> Flashbacks _____ | <input type="checkbox"/> Abuse (adult) _____ |
| <input type="checkbox"/> Obsessions _____ | <input type="checkbox"/> Distractible _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Hearing things _____ |
| <input type="checkbox"/> Panic _____ | <input type="checkbox"/> Seeing things _____ |
| <input type="checkbox"/> Suicidal thoughts _____ | <input type="checkbox"/> Loneliness _____ |
| <input type="checkbox"/> Suicidal acts _____ | <input type="checkbox"/> Other _____ |

Comments:

Is there anything else you would like to share:

I understand that by signing below, I am stating the above information is true.

Client Signature

Date

Parent (or guardian) Signature

Date



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1. What are the presenting problems? (i.e., depression, anxiety, etc.)

2. What is the client's mental diagnosis? When and where was client initially diagnosed?

3. How does your diagnosis affect your everyday living?

4. Please describe your symptoms that pertain to your mental diagnosis (i.e., lack of motivation, unable to function in society, etc.)

5. Do you need assistance in your day-to-day activities?

6. Are you currently being seen by a psychiatrist? If yes, please provide psychiatrist's contact information.



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7. What medications are you currently taking that pertain to mental diagnosis?

8. Current/previous medical conditions and medications?

9. Allergies?

10. Current physician's information?

11. Hobbies or entertainment?

12. What are client's goals?

13. Criminal history?



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14. Substance abuse?

15. Previous providers/treatment/legal 2000? (48 hour holds in hospital or for mental breakdowns).

16. Have you been hospitalized for any reasons within the last 3 months? If yes, when, and where?

17. What are the client's living arrangements? (i.e., alone, with family, has children in home, etc.)



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18. Additional resources needed?

19. Emergency Contact (please provide name, relationship, and contact number):

Referred by:

BHT Signature: _____

Date signed: _____



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Consent for Services

(Initial) _____ I agree to participate in the Bryant Community Outreach, LLC services/Outpatient treatment, basic skills training, psychosocial rehabilitation, group therapy, individual therapy, case management, etc. according to my treatment plan.

(Initial)_____ being the guardian o _____, I consent for him/her to participate with Bryant Community Outreach, LLC in the above-named services.

I give this permission with the understanding that the goal of the said program is to facilitate healthy relationship skills and improve life skill functioning.

I understand that others may be involved in my treatment and a release of information must be obtained. I agree to participate with the activities to be carried out to resolve and improve functioning. I also understand that others may be notified as a part of this team and to approach them with care.

I understand that I may withdraw my consent and release to participate with Bryant Community Outreach, LLC at any time.

Print Client/Guardian Name:

Client/Guardian Signature:

Date:



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Prohibition of Rediscovery: This information has been disclosed to you from records whose confidentiality is protected by both federal and state law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical information or other information is not sufficient for this purpose. Federal regulations state any person who violates any provision of this law shall be fined not more than \$500, in the case of a first offense, and not more than \$5000 for each subsequent offense. Federal regulations restrict any use of the information to investigate or prosecute any alcohol/drug abuse client.

Waiver of Liability and Agreement

This agreement releases Bryant Community Outreach, LLC employees, filed workers, and assigned PSR/BHT from all liability relating to injuries that may occur while being a passenger in a vehicle. By signing this agreement, I agree to hold Bryant Community Outreach, LLC entirely free from any liability, including financial responsibility for injuries incurred, regardless of whether injuries are caused by negligence. I acknowledge the risks involved in riding as a passenger in a vehicle. I am participating voluntarily, and all risks have been made clear to me.

By signing below, I forfeit all right to bring a suit against Bryant Community Outreach, LLC for any reason. I will make every effort to obey safety precautions as explained to me verbally and or listed in writing.

I, _____, fully understand and agree to the above terms.

Client Signature: _____ Date: _____

Date/Time Comments Worker

Client Progress Report: Notes, Case Management, Medication Training & Support

Week of: _____ Provider Name: _____

Today's Date: _____ Time: _____ to _____ Total hours: _____



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Medication Education & Support

Name of Medication/s:

- Ensuring medication intake (understanding frequency dosage/correct time of day medication/s are to be taken).
- Gathering information from other sources, such as family members, medical providers, social workers, and educators to form a complete assessment of the eligible requirements.
- Identification of medication count and time of month refill/s are needed.
- Education of not sharing/selling prescription medications to other individuals.

Client Name and Signature: _____

Provider and Signature: _____ As a Service provider, Bryant Community Outreach, LLC ensures each of our providers follow standards that maintain the highest level of professionalism. Bryant Community Outreach, LLC and our clients require that these standards are maintained by our service providers.

Please read our Code of Conduct carefully and return a signed copy to your Bryant Community Outreach, LLC contact.

Consent for Telehealth Consultation

1. I understand that my healthcare provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit because I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Consent to use telehealth via live video, store-and-forward, remote patient monitoring, and mobile health.

Live video, store-and-forward, remote patient monitoring, and mobile health are the technology services we will use to conduct telehealth videoconferencing appointments. It is simple to use. By signing this document, I acknowledge:

1. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

BRYANT COMMUNITY OUTREACH, LLC
1336 S Decatur Blvd Se B. LAS VEGAS NV 89102
725-312-2110

2. Though my provider and I may be in direct, virtual contact through the telehealth service, neither **live video, store-and-forward, remote patient monitoring, and mobile health** nor the telehealth service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The telehealth service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice, or care.
4. I do not assume that my provider has access to any or all of the technical information in the **live video, store-and-forward, remote patient monitoring, and mobile health** – or that such information is current, accurate or up-to-date. I will not rely on my healthcare provider to have any of this information in the **live video, store-and-forward, remote patient monitoring, and mobile health** service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- I have read or had this form read and/or had this form explained to me.
- I fully understand its contents including the risks and benefits of the procedure(s).
- I have been given ample opportunity to ask questions and any questions have been answered to my satisfaction.

By signing below, I am agreeing that I have read, understood, and agree to the items contained in this document:

Signature: _____

Date: _____

Patient Rights and Responsibilities Form

Director: DeShawn Bryant **Address:** 1336 S. Decatur Blvd Ste B. Las Vegas, NV 89102

Phone: 725-312-2110 **Fax:** 702- 3-4213 **Email:** bco.llc2024@gmail.com

As a patient at Bryant Community Outreach, you have the following rights:

I. Right to Information and Participation

1. **Right to Be Informed:** You have the right to receive clear, concise, and understandable information about your health condition, proposed treatments, potential risks and benefits, alternative treatments, and the likely course of your recovery. This information should be provided in a language you understand, and accommodations will be made for individuals with communication barriers.
2. **Right to Participate in Treatment Decisions:** You have the right to actively participate in decisions regarding your care. This includes the right to accept or refuse any recommended treatment, to the extent permitted by law. Your preferences and values will be respected in the decision-making process.
3. **Right to Informed Consent:** Before any treatment, procedure, or research participation, you have the right to give informed consent. This means you will be fully informed about the nature of the intervention, its purpose, potential risks and benefits, and any alternatives, allowing you to make a voluntary and educated decision.
4. **Right to Know the Identity of Care Providers:** You have the right to know the names, professional status, and experience of the individuals providing your care.
5. **Right to Access Medical Records:** You have the right to access your medical records, review them, and request amendments if you believe they are inaccurate or incomplete, in accordance with applicable laws and regulations.

II. Right to Privacy and Confidentiality

1. **Right to Confidentiality:** Your personal and medical information will be kept confidential and protected from unauthorized disclosure. Information will only be shared with your explicit consent, or as required by law (e.g., in cases of public health emergencies or mandated reporting).
2. **Right to Privacy:** You have the right to personal privacy during examinations, treatments, and consultations. Every effort will be made to ensure your modesty and discretion.

3. **Right to Control Disclosure:** You have the right to control who has access to your health information and to whom it can be disclosed, subject to legal and ethical limitations.

III. Right to Respect and Dignity

1. **Right to Respectful and Non-Discriminatory Care:** You have the right to receive care that is respectful, courteous, and free from discrimination based on race, ethnicity, color, religion, sex, national origin, age, disability, sexual orientation, gender identity, or any other protected characteristic.
2. **Right to Be Free from Abuse and Neglect:** You have the right to be free from all forms of abuse, neglect, exploitation, and harassment. Any concerns regarding such issues should be reported immediately.
3. **Right to Personal Values and Beliefs:** Your personal values, beliefs, and cultural background will be respected and considered in your care plan, as long as they do not compromise your health or the safety of others.
4. **Right to a Safe Environment:** You have the right to receive care in a safe and secure environment.

IV. Right to Complaint and Grievance Resolution

Right to Express Concerns and Complaints: You have the right to voice concerns, complaints, or grievances about your care without fear of reprisal.

Right to a Fair and Timely Resolution: Bryant Community Outreach will provide a clear process for addressing and resolving your complaints in a fair and timely manner. You will be informed of the outcome of any investigation into your complaint.

u aveter tt leac la t t t eState Nevada t e ac l t r e va ce r cedure d e
tre lve urc la tt ur at act a d t e r t t reed r retr ut r t e r
adver ec e ue ce a t e r duct l ac la t . Suc c la t a e addre ed r t
r tele et **Behavioral Health Certifications for Excellence in Nevada, 4126 Technology Way,
2nd Floor, Carson City, Nevada 89706. Phone: 1-775-684**

If you feel as if your rights have been violated, there is a process in the hospital for addressing any complaints or concerns. All complaints are taken seriously, and a thorough investigation is completed. No retaliation will be taken against a patient for reporting any rights violations or complaints. **Complaints within the facility may be directed to the Patient Advocate:**
Phone Number: 725-312-2110. Address: 1336 S. Decatur Blvd Ste B Las Vegas NV 89102.

Signature: _____

Date: _____

BRYANT COMMUNITY OUTREACH LLC

AUTHORIZATION TO OBTAIN AND/OR DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____
(Please Print Name) (Required)

I, the undersigned, authorize _____
(Hospital or Provider)

To disclose, in writing, protected health information (PHI) to:

(Person or Entity to whom information is to be disclosed)

And its attorneys and representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultations/examinations and/or diagnostic procedures performed at the above-referenced medical facility. I understand that I have the right to copy or inspect the PHI to be disclosed as permitted under Federal HIPAA law and state law.

I authorize the following PHI to be obtained/disclosed from my medical records:
Dates of Service or Date range _____
Body part(s) _____

PROTECTED RECORDS

REQUIRED: Please initial the lines below to indicate you authorize the release of the protected information specified, even if the categories do not necessarily apply to the patient's medical records.

- (Initial _____) Alcohol, Drug or Substance Abuse Treatment Records
- (Initial _____) HIV Testing & Related Information
- (Initial _____) Reproductive Healthcare Services
- (Initial _____) Mental or Behavioral Health Treatment Records
- (Initial _____) Genetic Testing

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. In order to revoke this authorization, I may, at any time, send written notification to the above-named hospital/provider. I understand that my revocation of this authorization is ineffective to the extent that the above-named hospital/provider has relied on this authorization to disclose PHI relating to me.

I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL OR STATE LAW. I understand that the above-named hospital/provider may not condition my treatment on whether I provide authorization for the requested use or disclosure.

IF THE PHI THAT IS DISCLOSED UNDER THIS AUTHORIZATION IS CONFIDENTIAL HIV/AIDS RELATED INFORMATION, PSYCHIATRIC OR OTHER PROTECTED MENTAL HEALTH INFORMATION, ALCOHOL OR DRUG ABUSE RELATED INFORMATION, OR REPRODUCTIVE HEALTH INFORMATION, THE RECIPIENT MAY BE PROHIBITED FROM REDISCLOSING THAT INFORMATION UNDER FEDERAL OR CONNECTICUT LAW.

I understand that if this disclosure contains information relating to HIV, behavioral health, alcohol, drug and/or substance abuse treatment, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of psychiatric or substance abuse information is NOT sufficient for this purpose.

I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT WHEN THIS AUTHORIZATION EXPIRES. Unless otherwise revoked, this authorization will expire on the following date/event: _____. If I fail to specify an expiration date/event, this authorization will expire six (6) months from the date signed.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this form relates to a Workers' Compensation matter. However, I understand that as a practical matter, my authorization may facilitate the processing and administration of my claim for Workers' Compensation benefits.

My signature below indicates that I have read and understand this authorization and its terms.

Signature of Patient/Parent/Legal Representative Date Relationship to Patient

PATIENT GRIEVANCE PROCEDURE

Every client receiving services at Bryant Community Outreach has the right to:

Be treated with dignity and respect. Receive services free from discrimination. Receive confidential treatment. Participate in treatment planning. Be informed of program rules and expectations. File grievances without retaliation. Request referrals and coordination of care. Receive information regarding confidentiality protections. Review records as permitted by law. Refuse services to the extent permitted by law.

HOW TO FILE A GRIEVANCE

Clients may submit grievances to:

Bryant Community Outreach 1336 S Decatur Blvd Ste B Las Vegas, NV 89102 Phone: 725-312-2110

Clients may also contact:

Nevada Division of Public and Behavioral Health Behavioral Health Certifications, located at 4150 Technology Way, Carson City, NV 89706, with a general phone number of (775) 684-4200.

Or

U.S. Department of Health and Human Services Office for Civil Rights; for complaints or questions via their toll-free number at **(800) 368-1019**, TDD: **(800) 537-7697**, or by email at OCRMail@hhs.gov.

BCO prohibits retaliation against any person filing a complaint or grievance.

CLIENT ACKNOWLEDGMENT OF PATIENT RIGHTS AND GRIEVANCE PROCEDURE

I acknowledge that I received information regarding my rights as a client, confidentiality protections, and grievance procedures.

Client Name: _____

Client Signature: _____

Date: _____

Staff Signature: _____

Date: _____

BCO NOTICE OF PRIVACY PRACTICES

THIS NOTICE EXPLAINS HOW YOUR MEDICAL AND SUBSTANCE USE DISORDER TREATMENT INFORMATION MAY BE USED AND SHARED AND HOW YOU CAN ACCESS IT. PLEASE READ IT CAREFULLY.

Bryant Community Outreach (BCO) is legally required to protect the privacy and security of your protected health information and substance use disorder treatment records. BCO complies with all applicable federal and state confidentiality laws, including:

42 CFR Part 2, the HIPAA Privacy Rule (45 CFR Parts 160 and 164), NRS 458.055, and other applicable Nevada confidentiality laws.

BCO must:

Protect the privacy of your health information, give you this Notice of Privacy Practices, notify you of a breach that may compromise your information, and follow the privacy practices described in this notice.

Your substance use disorder treatment records are protected by federal law. In general, BCO may not disclose information that identifies you as having or having had a substance use disorder unless:

You give written consent, a court order permits the disclosure, the disclosure is needed for a medical emergency, or the disclosure is otherwise allowed by law.

HOW BCO MAY USE AND DISCLOSE YOUR INFORMATION

Treatment

BCO may use and share your information to provide, coordinate, and manage your healthcare and treatment services.

- Coordinate care with physicians, therapists, counselors, peer support staff, and case managers.
- Make referrals to outside providers when needed.
- Support medication management, treatment planning, and continuity of care.

Payment

BCO may use and disclose your information to bill for and collect payment for treatment services.

- Submit claims to health plans and other payers.
- Request prior authorization and verify eligibility and benefits.
- Conduct utilization review and related payment activities.

Healthcare Operations

BCO may use your information for healthcare operations, such as:

- Quality assessment and improvement activities.
- Staff training, supervision, and credentialing.
- Business planning, auditing, compliance, and administrative functions.

YOUR RIGHTS

You have the right to:

- Ask for limits on
 - certain uses and disclosures.
 - Request confidential communications.
 - Inspect and obtain copies of your records.
 - Request corrections to your records.
 - Receive an accounting of certain disclosures.
 - Obtain a paper copy of this notice.
 - File a complaint without retaliation.
 - Revoke an authorization in writing when allowed by law.

BCO may deny some requests when permitted by law.

MINIMUM NECESSARY STANDARD

BCO follows the minimum necessary standard and discloses only the least amount of information needed to achieve the intended purpose.

Blanket releases of information are prohibited.

Each authorization must specifically identify:

- Who is releasing the information.
- Who will receive the information.
- The purpose of the disclosure.
- The specific information to be disclosed.
- The expiration date or event.
- Your right to revoke the authorization.

HIV related information requires a separate release.

CONFIDENTIALITY AND SECURITY SAFEGUARDS

BCO uses administrative, physical, and technical safeguards to protect confidential information. These safeguards include:

- Administrative safeguards, including privacy policies, workforce training, and access controls.
- Physical safeguards, including secured files and controlled access to treatment spaces.
- Technical safeguards, including systems and procedures designed to protect electronic information.

Client files are not stored in open or unsecured public areas. Doors between shared business spaces remain locked, and access to group rooms is secured during treatment activities.

BREACH NOTIFICATION

BCO will notify affected individuals without unreasonable delay if there is a breach of unsecured protected health information.

Client Signature: _____

Date: _____

BCO Staff Signature: _____

Date: _____

Bryant Community Outreach