CONSENT for TREATMENT & OFFICE POLICIES

I, _____ *authorize therapeutic services for* _____.
(Parent Guardian - please circle) *(Child's full name)*

I. Custody/Guardianship Issues

A. Consent for services can only be authorized by a current legal guardian.
B. If parents are separated, services are provided only with written consent of both parents.
C. For divorced parents, consent may be given by the parent authorized to make medical decisions. If medical decisions are ordered to be made jointly, consent of both parents is required.
D. Copies of legal paperwork (relevant pages) are requested to document the above information.

II. Confidentiality & Release of Information

A. At the family's request, Cynthia Spencer will contact other providers/staff to coordinate care.
B. *No information will be released about your child's therapeutic services without your written permission, except in the following cases:*
   - "In event of an emergency, I authorize Cynthia Spencer to provide relevant therapeutic information critical to my child's welfare." _____ (parent/guardian initials).
   - Insurance companies request dates of service and diagnosis codes. To authorize additional sessions, they request some details about treatment and progress.
   - The law requires Cynthia J. Spencer to report suspicions or evidence of child abuse, or child's/parent's expressed intention to harm oneself or others.
   - Child records in some circumstances may be subpoenaed. Cynthia J. Spencer will make every effort to protect confidentiality in these situations.

III. Fees: ***Payment is expected at the time of service, unless other arrangements have been made.***

A. Accepted forms of payment: Cash or Check
B. Insurance Charges: Cynthia Spencer does not accept insurance at this time.
C. Private Pay Charges: Intake $140, Individual visit $120.00. Individualized private pay arrangements can be made at or before the 1st visit.
D. No-show / Late cancel: $65.00 for no-shows and cancellations with less than 24 hrs. notice.

I have read this form, discussed my questions with Cynthia Spencer, and agree to its terms.

_____ _____ _____ _____
Parent/Guardian signature *Date* *Parent/Guardian signature* *Date*

Cynthia J. Spencer MC, LPC

SERVICES & FEE SCHEDULE

Intake	$140 / hr
Individual session	$120 / hr
Telephone Consultations: *with parents, doctors, school staff, parenting coordinators, case workers & other professionals.*	$30.00 / quarter hour
Observation at school or daycare (1 - 2 hour visit)	$ 130.00 / hr
Attendance at school staffings / IEP meetings	$ 130.00 / hr
Travel time reimbursement (round trip)	$ 25.00
"No Show" or late cancellation (less than 24 hrs notice) *(To cancel a Monday appt., please call prior Friday by 10am)*	$ 65.00
Returned Check Fee	$25.00 minimum

Please sign to acknowledge receipt of this information.

_____ _____

(Name of Parent or Guardian) **(Date)**

Would you like a copy at this time? ☐ *yes* ☐ *no*

NOTICE OF PRIVACY PRACTICES

Effective 5/29/07

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Contact Information:

If you have any questions regarding the Privacy Policy, you may contact Cynthia Spencer 480-235-3124. You may also send written inquiries to:

5040 E. Shea #268

Phoenix, AZ 85254

Who Will Follow This Notice:

Cynthia J. Spencer, private practitioner

How We Safeguard Your Protected Health Information (PHI):

I understands that past, present or future medical information about you and your health is personal. We are committed to protecting health information that we have either received or created. This notice will explain how, when and why we may use, share and disclose Protected Health Information (**PHI**) about you. We may change the terms of our notice at any time. If changes are made to this privacy notice you will be notified and can request a copy of the revised notice. The most up to date policy will be posted at I at the address listed above. I is required by law to make reasonable efforts to protect health information that could identify you from unauthorized disclosure.

How We May Use Your Protected Health Information:

We may use PHI and share it with others for a variety of reasons. Sometimes we must have your written agreement to share PHI. Sometimes we are required/allowed by law to use or share your PHI without your written consent.

Treatment: We may disclose your PHI to provide, manage and/or coordinate your health care and related services. Your PHI may be shared with your treating health professional, the mental health team, supervisors and directors.

For Payment: We may use your PHI to obtain payment for your health care services. This may include sharing information with your insurance company to include payment for service, to determine eligibility for coverage or to establish premiums.

For Health Care Operations: We may use your PHI in various ways that support the daily functions of the Center. These may include, but are not limited to, quality analysis, licensing and accreditation requirements, staff development, training and consultation, and for demographic purposes. Additionally, we may use your PHI with our accountants or attorneys for audits or litigation. Unless otherwise specified, you may be called by name in the lobby, we may leave voice messages on your telephone and we may send appointment reminders and or other treatment related literature to your home.

Individuals Involved in Your Care: We may disclose PHI to a person that you identify that is involved in your health care. We may also give PHI to someone who helps pay for your care.

For Public Health Activities: We may share PHI when we are required to collect information about disease or injury, or to report information to a public health authority.

For Health Oversight Activities: We may share PHI with an agency responsible for monitoring the health care system for activities authorized by law. These may include, audits, investigations, inspections and licensure.

Related to Decedents: We may share PHI relating to an individuals death with coroners, medical examiners or funeral directors and to organ procurement organizations.

For Research Purposes: We may, in certain and specific circumstances, use your PHI in order to assist in medical or psychiatric research.

To Prevent Threats to Health or Safety: We may share your PHI with law enforcement or other persons involved in preventing or reducing threat of harm to avoid a serious threat to health or safety.

For Specific Government Functions and National Security: We may share PHI with authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may share your PHI with correctional facilities.

As Required By Law: We will disclose PHI about you when required to do so by federal, state or local law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requesting.

Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

- As required by Law;
- In response to a court order, subpoena, warrant, summons, administrative request or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

By law we must have your written permission to use or give out your PHI for any purpose not outlined in this policy. If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights Regarding Your Protected Health Information: You have the following rights related to PHI

* **Right to Request Restrictions:** You have the right to request limitations on how we use your PHI. We will consider your request, but do not have to agree to it. If we do agree to the restrictions, we will put the agreement in writing and follow it, except in emergency situations or as required by law.

* **Right to Request Confidential Communications:** You have the right to ask that we communicate with you in a specific manner and in a specific location. We will accommodate all reasonable requests.

* **Right to Inspect and Copy Your PHI:** You may make a written request to inspect and copy your PHI. In some situations, we may deny your right to view and copy your PHI in it's entirety. If your request is denied, you will receive written notice, which you may be able to appeal. You may also request a summary of the PHI in lieu of the complete record. If your request is approved, there may be a charge for copying and we may require 7-10 business days to complete the copying.

* **Right to Request Amendments:** If you believe there is a mistake, or missing information in your PHI, you may submit a written request for correction/amendment that includes reasons supporting your request. We may deny the request if we determine that the PHI is (1) complete and correct, (2) was not created by us and is not part of our records, (3) is a type of information that we cannot disclose. You will be notified in writing if your request is denied and may appeal the decision.

* **Right to Tracking of Disclosures:** You have the right to request a list of the disclosures we made of your PHI including the person receiving the information, the date and the purpose of the disclosure. This list will not include disclosures for treatment, payment or health care operations, or any release of information we made to you or to those you authorized, your family, or any release to national security or intelligence authorities. This list may not include any disclosures made before 4/14/03 and may not include disclosures that law enforcement or health authorities asked us not to list. You may request this list in writing. Copying charges may apply and we may require 7-10 business days to complete copies.

* **Right to Receive This Notice:** You have the right to receive a paper copy of this notice upon request

Complaints: If you believe your privacy has been violated or disagree with a decision we made regarding releasing or using your PHI, you may appeal in writing to Cynthia Spencer. You may also file a complaint in writing or via email to the Secretary of the U.S. Department of Health and Human Services.

Office of Civil Rights
US Dept of Health & Human Services
50 United Nations Plaza, Room 322
San Francisco, California 94102

OCRComplaints@hhs.gov

We will not discriminate against you in anyway because you file a complaint.

I have read this document, received a copy of this document, and have had any questions about this document answered.

_____ _____ _____

Print Guardian Name/Guardian Signature **Date**

_____ _____ _____

Print Witness Name/Witness Signature **Date**

Today's Date: _____ Admission Date (1st session):_____ (completed by therapist)

Client/Child Information

Client: _____ Address: _____

City: _____ County: _____ State: _____ Zip: _____

Age: _____ DOB: ____/____/____ Social Security Number: _____ Sex: Male ☐ Female ☐

Race: _____

Client resides with: _____ Relationship to child: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell/Pager: (_____)_____

Family Information (include only those persons currently living in the home)

First and Last Name	Relationship to Client	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legal Guardian/Legal Custody IF other than person listed above, complete the following:

Legal Guardian Name: _____ Relation to Client: _____

Address: _____ Phone: _____

In case of emergency, please contact: _____ Phone: (_____)_____

Relationship to Client: _____

FACE SHEET (CONT)
PAGE 2

Insurance Information
Is **client** covered by insurance? Yes ☐ No ☐ Insurance Company: _____

Insured Party's Name: _____ Phone Number: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell/Pager: (_____)_____

Policy #: _____ DOB: _____ Employer: _____

Client Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

PLEASE PROVIDE INSURANCE CARD FOR BENEFIT VERIFICATION

Others contacts:

School Name and Teacher: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Parent/Guardian Signature: _____ **Date:** _____

Name Printed of Person Completing Form: _____

INTAKE ASSESSMENT

Client Name: D.O.B.: Today's Date:

Source(s) of Information:

Name, Title & Credentials of Person Completing Form:

PRESENTING CONCERNS

1. Describe the reason(s) you are seeking help today:

2. Describe the symptoms the child is exhibiting: (include frequency, intensity and duration)

3. What has been done so far to address the concerns? What helps? What makes the problems worse?

4) Has the child received behavioral health services in the past? ☐ no ☐ yes, explain (include name of agency, individual providing treatment, inpatient/outpatient, duration of treatment, psychological evaluations, describe what was helpful about the treatment):

RISK FACTORS

5. Has the child allegedly experienced any of the following: (check all that apply)

☐ physical abuse ☐ sexual abuse ☐ neglect ☐ witness to violence

☐ inconsistent/multiple caregivers ☐ other

Explain:

6. Is the child currently, or have a history of, being a danger to/harming themselves?

☐ no ☐ yes, explain:

(if you answered yes, please complete full safety plan and risk assessment)

7. Is the child currently, or have a history of, being a danger to/harming others? (including sexual reactivity)

☐ no ☐ yes, explain:

(if you answered yes, please complete full safety plan and risk assessment)

8) Does the child have any sexual behaviors of concern? ☐ no ☐ yes, explain:

MEDICAL

9) Does the child have any medical problems? ☐ no ☐ yes, explain (include symptoms, medical diagnosis, treatment given):

10) Has the child ever had a head injury? ☐ no ☐ yes, explain:

11) Did the child meet developmental milestones (crawling, walking, talking, toileting) on time?

☐ yes ☐ no, explain:

12) Is the child currently, or been in the past, on medications? ☐ no ☐ yes (list name, dosage, reason given):

FAMILY/ENVIRONMENT

13) Describe the family history and current living environment: (where, who lives in the home, daily routines etc)

14) Describe the child and the family support system:

15) Describe any major life stressors or recent changes:

16) Is there a family history of mental health problems/diagnosis? ☐ no ☐ yes, explain:

SCHOOL

17) Describe the child's school setting, academic progress and peer relations:

18) Does the child have any special educational needs? (IEP, 504 plan, ED) ☐ no ☐ yes, explain:

LEGAL

19) Is there currently, or has there been in the past, any legal involvement? (include custody, pending litigation, criminal investigations) ☐ no ☐ yes,

explain:

SUBSTANCE USE

20) Has the child been exposed to or witnessed drug use? ☐ no ☐ yes, explain:

21) Has the child used drugs? ☐ no ☐ yes, explain: (type, frequency, duration of use)

22) Is there a family history of substance use? ☐ no ☐ yes, explain: (describe any co-occurring disorder)

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23) ARE THERE OTHER SYSTEMS INVOLVED? ☐ no ☐ yes, (check all that apply)

☐ CPS ☐ PD ☐ DDD ☐ RBHA ☐ other:

Explain:

MENTAL STATUS EXAM

1. Describe the child's appearance and general presentation:

2. Describe the child's mood/affect:

3. Describe the child self concept:

4. Describe the child's thought content, thought process, sense of judgment and impulse control:

5. Describe the child's motor activity and speech:

6. Describe the interactions between the child and the parent; how they relate to one another:

7. Describe your general impressions of the parent-child relationship:

CLINICAL IMPRESSIONS: (include recommendations for further assessment/treatment)

DIAGNOSIS

Axis I:

DSM-IV Diagnosis DSM-IV Code

DSM-IV Diagnosis DSM-IV Code

DSM-IV Diagnosis DSM-IV Code

DSM-IV Diagnosis DSM-IV Code

Axis II:

DSM-IV Diagnosis DSM-IV Code

DSM-IV Diagnosis DSM-IV Code

Axis III: (medical conditions)

Axis IV: Psychosocial or Environmental Stressors (check all that apply):

☐primary support group ☐ educational problems ☐marital problems

☐ housing problems ☐ interaction with legal system

☐ family problems ☐ substance use in the home

☐ other, explain:

Axis V: (CGAS/GAF Score):

_____ _____ _____

Signature of person completing form Credentials/job title Date

_____ _____ _____

Clinical Director Signature Credentials Date

SAFETY PLAN

Client Name: Date:

Client #:

1) Client is currently (within the past 30 days) a danger to others (via physical aggression or sexual reactive behaviors): ☐ **no** ☐ **yes, describe behaviors:**

2) Client is currently (within the past 30 days) a danger to self:
☐ **no** ☐ **yes, describe behaviors:**

3) Client has a history (more than 30 days ago) of danger to others:
☐ **no** ☐ **yes, describe behavior and when it occurred:**

4) Client has a history (more than 30 days ago) of danger to self:
☐ **no** ☐ **yes, describe behavior and when it occurred:**

☐ Client is **NOT** thought to be a danger to self and others at this time. A full safety plan is not needed at this time.

If answered YES to question#1 and/or #2 above, complete the remainder of this form as well as the Risk Management Form.

Relevant History:

Description of Behaviors:

Triggers or Pattern of Behaviors:

Planned Response:

Emergency Contacts: 1) Magellan Crisis 602-222-9444 2) Childhelp Hotline 1-800-4-a-child 3)

* If there are any identifiable victims, has the therapist notified them? Yes ☐ No ☐ N/A ☐
* Was Law Enforcement, fire or medical personnel notified? Yes ☐ No ☐ N/A ☐
* Is voluntary or involuntary hospitalization needed? Yes ☐ No ☐
* If other precautions are needed, what steps have been taken: _____

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature/credentials Date

fax

Treatment Plan

Client Name: Client ID #: Therapist: Date: Review Date:
(on or before 6 months from today)

Presenting issue:

Goals & Objectives	Method (child-directed, art, play, CBT, trauma focused, parent skills, feelings/coping etc)	Frequency (Weekly, bi-weekly, monthly etc)	Current level of Functioning	Desired level of Functioning	Target Date	Goal Achieved Y/N ? Date

Mode of Treatment: (check all that apply)

☐ Individual ☐ Family ☐ Group ☐ Other

Discharge plan & Referrals:

Parent/Legal Guardian _____ Date _____

Therapist Signature & Credentials _____ Date _____

Clinical Director Signature & Credentials _____ Date _____

Authorization for Release of Information

I, _____, hereby authorize
(Client, former client, parent/guardian or other authorized person)

Cynthia J. Spencer

☐ To disclose information to
☐ Obtain information from
☐ Exchange information with

Name: _____

Address: _____

City, State, Zip: _____

Regarding: _____ _____ _____
(Client name) (Social Security Number) (DOB)

The following information may be disclosed:

___Case Summary
___Discharge Summary
___Treatment Plan
___ Progress Notes
___ Reciprocal verbal communication
___ Other:

Purpose of disclosure: _____ Expiration date: _____
(one year or less from today's date)

To the party receiving this information: If the records disclosed to you pursuant to this authorization contain information related to alcohol and/or drug abuse, HIV/AIDS related information, and/or psychiatric, mental health information, the information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of such information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

This authorization is subject to revocation at any time by written notification to Cynthia Spencer and will automatically expire at revocation date or one year from the date on which it was signed.

In consideration of this authorization, I hereby release the above parties from any legal liability resulting from the release of this information.

Signature: _____ Date: _____
(Client, former client, parent/guardian or other authorized person)

Witness: _____ Date: _____

CLIENT RIGHTS

A client has the following rights:

1. To be treated with dignity, respect, and consideration;

2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;

3. To receive treatment that:

    a. Supports and respects the client's individuality, choices, strengths, and abilities;

    b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and

    c. Is provided in the least restrictive environment that meets the client's treatment needs;

4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;

5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;

6. To have grievances considered by a licensee in a fair, timely, and impartial manner;

7. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;

8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;

9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting, or exercising the client's rights;

10. To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);

11. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:

    a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);

b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37;

c. For video recordings used for security purposes that are maintained only on a temporary basis; or

d. As provided in R9-20-602(A)(5);

12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);

13. To review the following at the agency or at the Department:

a. This Chapter;

b. The report of the most recent inspection of the premises conducted by the Department;

c. A plan of correction in effect as required by the Department;

d. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and

e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;

14. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;

15. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;

16. To be offered or referred for the treatment specified in the client's treatment plan;

17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;

18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered

by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. § 36-512;

19. To be free from:

a. Abuse;

b. Neglect;

c. Exploitation;

d. Coercion;

e. Manipulation;

f. Retaliation for submitting a complaint to the Department or another entity;

g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;

h. Treatment that involves the denial of:

i. Food,

ii. The opportunity to sleep, or

iii. The opportunity to use the toilet; and

i. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;

20. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;

21. To control the client's own finances except as provided by A.R.S. § 36-507(5);

22. To participate or refuse to participate in religious activities;

23. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene;

24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan;

25. To participate or refuse to participate in research or experimental treatment;

26. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;

27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;

28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility; and

29. If receiving treatment in a residential agency, an inpatient treatment program, a Level 4 transitional agency, or a domestic violence shelter:

a. If assigned to share a bedroom, to be assigned according to R9-20-405(F) and, if applicable, R9-20-404(A)(4)(a);

b. To associate with individuals of the client's choice, receive visitors, and make telephone calls during the hours established by the licensee and conspicuously posted in the facility, unless:

i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;

ii. The client is informed of the reason why this right is being restricted; and

iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;

c. To privacy in correspondence, communication, visitation, financial affairs, and personal hygiene, unless:

i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;

ii. The client is informed of the reason why this right is being restricted; and

iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;

d. To send and receive uncensored and unopened mail, unless restricted by court order or unless:

i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;

ii. The client is informed of the reason why this right is being restricted; and

iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;

e. To maintain, display, and use personal belongings, including clothing, unless restricted by court order or according to A.R.S. § 36-507(5) and as documented in the client record;

f. To be provided storage space, capable of being locked, on the premises while the client receives treatment;

g. To be provided meals to meet the client's nutritional needs, with consideration for client preferences;

h. To be assisted in obtaining clean, seasonably appropriate clothing that is in good repair and selected and owned by the client;

i. To be provided access to medical services, including family planning, to maintain the client's health, safety, or welfare;

j. To have opportunities for social contact and daily social, recreational, or rehabilitative activities;

k. To be informed of the requirements necessary for the client's discharge or transfer to a less restrictive physical environment; and

l. To receive, at the time of discharge or transfer, recommendations for treatment after the client is discharged.