RON BUTCHER, LCSW, BCD

143 Ridgeway Dr., Ste. 301

Mailing address: P.O. Box 60207

Lafayette, LA 70596

(337) 278-7263 cell

ronbutchermsw@gmail.com

ronbutchermsw@bellsouth.net

Patient:_____Age:_____DOB:_____

Gender:_____ Marital Status:_____

Address:_____City:_____Zip:_____

Phone cell:_____Phone other:_____

SSN:_____Education level_____

EMAIL ADDRESS:_____

Emergency Contact (name, relationship, phone

number):_____

_____

Primary Care Physician:_____Phone:_____

Referral Source:_____Phone:_____

Insurance Carrier:_____

Policy or Member ID:_____ Group #:_____

Policy Holder/Guarantor (if different from patient):

Name:_____Relationship to Patient:_____

DOB: _____SS#:_____Phone#:_____

If address if different from above:_____

Employer or school name and address:

_____

If minor, school name and

address:_____

INFORMED CONSENT FOR TREATMENT

I, _____(name of patient), agree and consent to participate in behavioral health care services, including telehealth, offered and provided at/by Ron Butcher, LCSW, BCD, LCSW #1823, a behavioral healthcare provider. I have been informed and understand the benefits and risks of telehealth. Examples of potential benefits are immediate access to services, convenient scheduling, privacy, and reduced or eliminated transportation barriers. Examples of potential risks are the lack of visual and auditory cues, delayed responses, the need for crisis services, confidentiality breaches, and technological failures. I consent to treatment by telehealth, and have elected to use telehealth.

I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral healthcare providers directly supervising the services received by the patient.

If the patient is under age 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

I have been provided education on my primary diagnosis of _____

Signature: _____Date: _____

Relationship to Patient (if applicable): _____

TELEHEALTH

I, Ron Butcher, certify that I verified the identity of _____for purposes of telehealth services.

_____ Date: _____

PATIENT RIGHTS:

Privacy and Confidentiality: All records and communications about me will be treated confidentially in compliance with applicable state and federal laws.
Complete and Current information: All information regarding your diagnosis, treatment and prognosis, the nature and purpose of therapy and potential adverse effects associated with the therapeutic process.
Clear Instructions: Clear and precise information concerning the need for follow-up visits, referral to other healthcare professionals, or additional measures necessary to achieve the desired outcome for your diagnosis.
Accept or Refuse Treatment: You as a patient have the right to accept any or all of the treatment plan after receiving a complete explanation.
A Copy of Medical Records: You may receive a copy of your records after a payment of reasonable copying fees and account balances, if any.
Information about your account: You have the right to receive the amount and purpose of charges and policies regarding payment of charges as well as procedures for resolving conflicts in the settlement of the patient's account.

PATIENT RESPONSIBILITIES:

Patient Information: Provide correct and complete information about your health and contact information.
Follow the Treatment Plan: Follow instructions by your Mental Health Practitioner unless you notify him of concerns.
Take Responsibility for your Actions: If you refuse treatment or do not follow your treatment provider's instructions.
Meet the financial obligations for your care as soon as possible.
Call the office if unable to keep scheduled appointments and arrive on time for scheduled appointment.

INFORMED CONSENT:

By signing below I acknowledge reading, understanding, and agreeing with the above policies and information. I understand that if I do not understand or have any questions about these policies, I may discuss them with my provider.
I authorize any holder of medical or other information about me to release to the social security administration, health care financing administration, it's agents or carriers, or the insurance company any information needed for this or a related medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of other parties who may be responsible for paying for my treatment .

PATIENT NAME (PRINT): _____

SIGNATURE:_____DATE:_____

IF PATIENT IS A MINOR:

PARENT/GUARDIAN NAME (PRINT): _____

SIGNATURE: _____DATE:_____

Or patient refused to sign _____.

We believe that everyone benefits when there is a clear and definite understanding of our financial policy prior to treatment.

1. PATIENTS WITHOUT INSURANCE: All patients without insurance are required to pay in full for the service rendered at the time of the appointment.

2. ALL PATIENTS WITH MANAGED CARE PLANS: It is your responsibility to know and understand your managed care plan. Generally, these plans require payment of deductibles and / or copayments. Patients are required to pay for services according to their insurance contract at time of service.

3. ALL PATIENTS WITH INSURANCE: If our office is contracted with your insurance company, we will file your insurance claims if you provide us with the proper information along with a copy of your current insurance card. In the event your insurance overpays, we will refund the overpayments to you promptly upon written request. Otherwise, overpayments will be credited to your account for future services. If your insurance company does not pay within 60 days, you are responsible for the remaining balance and you will be billed accordingly.

4. CANCELLATION POLICY: There is a charge for failed appointments / late cancellations of appointments when less than a 24-hour notice is given by the patient. You will be charged the full fee for the service which would have been rendered. We cannot bill insurance companies for these appointments. Reminder calls to our patients are offered as a courtesy.

5. DELIQUENT ACCOUNTS: In the event Ron Butcher, LCSW, BCD is forced to pursue the balance of your account through a collection process, the patient will be responsible for any and all costs and fees associated with this process.

Payment for services rendered may be made by check, cash or credit card (Mastercard, Visa, Discover, or American Express). There is a $35 fee for NSF checks.

I have read and agree with the terms of this agreement.

Responsible Party Signature: _____Date: _____

I authorize payment of insurance benefits to Ron Butcher, LCSW, BCD for services rendered.

Responsible Party Signature: _____Date: _____

PATIENT HISTORY AND QUESTIONNAIRE

NAME: _____ AGE: _____

REFERRED BY: _____ OCCUPATION: _____

PRESENTING PROBLEMS

Briefly describe your current difficulties:

_____

_____

_____

_____

How long has this been a concern to you? _____ When was this problem first noticed?

_____

What seems to make the problem worse? _____

Have any other family members had similar problems? Yes No

If yes whom? _____

Are you on any medication at this time for the current problem? Yes No please list:

_____

Describe any major events that might be related to the problem (e.g. death, divorce, abuse, etc.):_____

_____

_____

DEVELOPMENTAL HISTORY

As far as you know, were there any problems with your mother's pregnancy or delivery of you?

Yes / No Details: _____

Did you have any childhood illnesses? _____

Yes _____ No _____ If no, details: _____

EDUCATIONAL HISTORY:

Schools Attended: Dates Degrees

Universities: _____

High School: _____

Special Education: _____

MEDICAL HISTORY:

Please list medications below:

MEDICATION	AGE	REASON PRESCRIBED
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any Medication allergies: _____

Any other allergies: _____

Have you ever suffered from a head injury which caused confusion or loss of consciousness? Yes No

Place a check next to any illness or condition that you have had. When you check an item, also note the approximate date or age at the time of the illness.

ILLNESS/CONDITION	AGE OR DATES	ILLNESS/CONDITION	AGE OR DATES
___AIDS/ or HIV positive	_____	___Fainting Spells	_____
___Allergies	_____	___Fetal Alcohol Syndrome	_____
___Anemia	_____	___Fever	_____
___Aneurysm	_____	___Guillain-Barre Syndrome	_____
___Anoxia	_____	___Head Injury	_____
___Arteriovenous Malformation	_____	___Headaches	_____
___Arthritis	_____	___Heart Disease/Problems	_____
___Asthma	_____	___Lead Poisoning	_____
___Ataxia	_____	___Hepatitis	_____
___Automobile Accident	_____	___Herpes	_____
___Back Pains/Problems	_____	___High Blood Pressure	_____
___Bleeding Problems	_____	___Jaundice	_____
___Blood Disorders	_____	___Leukemia	_____
___Bone/Joint Disease	_____	___Malnutrition	_____
___Broken Bones	_____	___Meningitis	_____
___Cancer	_____	___Muscular Disease	_____
___Chorea	_____	___Pain Problems	_____
___Coma	_____	___Paralysis	_____

___Cystic Fibrosis _____
___Dazed/Unconscious _____
___Dementia _____
___Diabetes _____
___Dysarthria _____
___Dyspraxia (Apraxia) _____
___Ear Infections (PE Tube) _____
___Other Ear Problems _____
___Eczema/Hives _____
___Electrical/Chemical Shock _____
___Encephalitis _____
___Stroke _____
___Sunstroke/Heat Exhaustion _____
___Pituitary Disorder _____
___Pneumonia _____
___Poisoning _____
___Poliomyelitis _____
___Rheumatic Fever _____
___Scarlet Fever _____
___Sensory Loss _____
___Sexual Molestation _____
___Sexually Trans. Disease _____
___Speech/Language Problem _____
___Epilepsy, Seizures, Fits _____
___Suicide Attempts/Thoughts _____
___Thyroid Disorder/Problem _____

Test (Please check and give age):

___Electroencephalogram (EEG) _____
___Skull X-Rays _____
___CT Scan _____
___MRI Scan _____
___BRAM Scan _____
___Ophthalmologic (Vision) _____
___Tuberculosis _____
___Tumor _____
___Visual Problems _____
___Whooping Cough _____
___Evoked Potentials _____
___Audiological Evaluation _____

Other Medical Problems:_____

_____

Are there any medical illnesses that run in your family? Yes _____ No _____

If yes, details: _____

Is there anyone in your family who has had problems with anxiety or depression? Yes _____ No _____

If yes, details: _____

Is there anyone in your family who has abused alcohol or other drugs? Yes _____ No _____

If yes, details: _____

Is there anyone in your family who has had psychiatric illness? Yes _____ No _____

If yes, details: _____

Is there anyone in your family who has been in trouble with the law? Yes _____No _____

If yes, details: _____

Is there anyone in your family who has had seizures or other neurological problems? Yes ____ No ___

If yes details: _____

Is there anyone in your family who has had Tourette's syndrome or vocal tics? Yes _____ No _____

If yes details:_____

Is there anyone in your family who has movement disorder or any other unusual movements? Yes

__No

If yes details: _____

Is there anyone in your family who has heart problems? Yes _____ No _____

If yes details: _____

Is there anyone in your family who has high blood pressure? Yes _____ No _____

Is there anyone in your family who has had attention problems?

If yes details: _____

Is there anyone in your family who has had learning disabilities? Yes _____ No _____

If yes details: _____

SOCIAL HISTORY

Do you smoke? Yes _____ No _____ If yes, how much? _____

How much caffeine do you drink, including caffeinated tea and soda? _____

Any current or past substance abuse problems including alcohol? Yes _____ No _____

If yes details: _____

Briefly describe your work history:

_____

_____

Have you ever been in trouble with the law? Yes _____ No _____

Describe: _____

What is your current marital status? _____

List names and ages of children: _____

Are you currently in an intimate relationship?

Yes _____ No _____ If yes, for how long? _____

Do you have trouble in your relationship with others? Yes _____ No _____

If yes, details: _____

How many intimate relationships with others? _____

_____

You have been asked a lot of questions. Can you think for a minute and describe any other problems you have that might be related to what you came here for?

_____

_____

_____

_____

_____

_____

_____

_____

I certify that all statements made and all questions answered are true and accurate to the best of my knowledge.

SIGNATURE _____ DATE_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Ron Butcher, LCSW #1823 Patient: _____Date: _____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Ron Butcher LCSW #1823 Patient: _____Date: _____

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score: _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Ron Butcher, LCSW #1823 Name: _____ Date: _____

State of Louisiana
Louisiana Department of Health
Office of Behavioral Health
Rights of Patient
(LA Revised Statutes 28: Sec 171; 53; 55)

§171. Enumerations of rights guaranteed

A. No patient in a treatment facility pursuant to this Chapter shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the state of Louisiana, or the Constitution of the United States solely because of his status as a patient in a treatment facility. These rights, benefits, and privileges include, but are not limited to, civil service status; the right to vote; the right to privacy; rights relating to the granting, renewal, forfeiture, or denial of a license or permit for which the patient is otherwise eligible; and the right to enter contractual relationships and to manage property.

B. No patient in a treatment facility shall be presumed incompetent, nor shall such person be held incompetent except as determined by a court of competent jurisdiction. The determination of incompetence shall be separate from the judicial determination of whether the person is a proper subject for involuntary commitment.

C.(1) The patient in a treatment facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone, and visitation. These rights may be restricted by the director of the treatment facility if sufficient cause exists and is so documented in the patient's medical records. The patient's legal counsel, as well as his next of kin or responsible party must be notified in writing of any such restrictions and the reasons therefor. When the cause for any restriction ceases to exist, the patient's full rights shall be reinstated. A patient shall have the right to communicate in any manner in private with his attorney at all times.
(2) The director of a treatment facility shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage, and telephone usage funds shall be provided in reasonable amounts to recipients who are unable to procure such items.
(3) Reasonable times and places for the use of telephones and for visits may be established in writing by the director of any treatment facility. However, the times and places established by the director must allow patients, at a minimum, reasonable daily communication by telephone and visitation. These rights may be restricted by the director of the treatment facility if sufficient cause exists and is so documented in the patient's medical records. The patient's legal counsel, as well as his next of kin or responsible party, must be notified in writing of any such restrictions and the reasons therefor. When the cause for any restriction ceases to exist, the patient's full rights shall be reinstated.
(4)(a) The director of any substance abuse treatment facility may restrict the visitation rights of a patient who is voluntarily admitted to such treatment facility under the provisions of R.S. 28:52, 52.1, 52.2, 52.3, and 52.4 for the initial phase of treatment but no longer than seven days unless good cause exists to extend the restriction and is so documented in the patient's record. This restriction shall not apply to visitation by the patient's attorney, or if he is not represented by counsel, the mental health advocate, or the patient's minister. This restriction shall also not apply to a parent or legal guardian of a patient who is a minor unless the director determines that good cause exists that such restriction shall be in the best interest of the patient and is so documented in the patient's record. When the facility director determines the need to restrict visitation of new patients he shall post notice of such restriction in places prominent to all new admissions, and shall inform each new patient of the restriction prior to the admission of the patient, and the length and duration thereof, and further, that such restriction may be extended on an individual basis as determined to be in the patient's interest by the treatment staff with the concurrence of the medical director.
(b) Nothing herein shall be construed to further restrict other forms of patient communication as permitted in this Section, nor shall this restriction apply to mental health treatment facilities.

D. Seclusion or restraint shall only be used to prevent a patient from physically injuring himself or others. Seclusion or restraint may not be used to punish or discipline a patient or used as a convenience to the staff of the treatment facility. Seclusion or restraint shall be used only in accordance with the following standards:
(1) Seclusion or restraint shall only be used when verbal intervention or less restrictive measures fail. Use of seclusion or restraint shall require documentation in the patient's record of the clinical justification for such use as well as the inadequacy of less restrictive intervention techniques.
(2) Seclusion or restraint shall only be used in an emergency. An emergency occurs when there is either substantial risk of self-destructive behavior, as evidenced by clinically significant threats or attempts to commit suicide or to inflict serious harm to self, or a substantial risk or serious physical assault on another person, as evidenced by dangerous actions or clinically significant threats that the patient has the apparent ability to carry out.
(3) A written order from a physician, psychologist, medical psychologist, or psychiatric mental health nurse practitioner acting within the scope of his institutional privileges shall be required for any use of seclusion or restraint. If, however, no physician, psychologist, medical psychologist, or psychiatric mental health nurse practitioner is immediately available, a registered nurse who has been trained in management of disturbed behavior may utilize seclusion or restraint. The nurse or the nursing supervisor shall then immediately notify a physician, psychologist, medical psychologist, or psychiatric mental health nurse practitioner with institutional authority to order seclusion or restraint and provide him with sufficient information to determine whether seclusion is necessary and whether less restrictive interventions have been tried or considered. The physician, psychologist, medical psychologist, or psychiatric mental health nurse practitioner may issue a telephone order for seclusion or restraint, if such order is indicated.
(4) Written orders for the use of seclusion or restraint shall be time limited and not more than twelve hours in duration. The written order shall include the date and time of the actual examination of the patient, the date and time that the patient was placed in seclusion or restraint, and the date and time that the order was signed.
(5) A renewal order for up to twelve hours of seclusion or restraint may be issued by a physician, psychologist, medical psychologist, or psychiatric mental health nurse practitioner with institutional authority to order seclusion or restraint after determining that there is no less restrictive means of preventing injury to the patient or others. If any patient is held in seclusion or restraint for twenty-four hours, the physician, psychologist, medical psychologist, or psychiatric mental health nurse practitioner with institutional authority shall conduct an actual examination of the patient and document the reason why the use of seclusion or restraint beyond twenty-four hours is necessary, and the next of kin or responsible party shall be notified by the twenty-sixth hour.
(6) Staff who implement written orders for seclusion or restraint shall have documented training in the proper use of the procedure for which the order was written.
(7) Periodic monitoring and care of the patient shall be provided by responsible staff. A patient in seclusion or restraint shall be evaluated every fifteen minutes, especially in regard to regular meals, water, and snacks, bathing, the need for motion and exercise, and use of the bathroom, and documentation of these evaluations shall be entered in the patient's record.
(8) Patients shall be released from seclusion or restraint as soon as the reasons justifying the use of seclusion or restraint subside. If at any time during the period of seclusion or restraint a registered nurse determines that the emergency which justified the seclusion or restraint has subsided and a physician, psychologist, medical psychologist, or psychiatric mental health nurse practitioner with institutional authority to order seclusion or restraint is not immediately available, the patient shall be released. At the end of the period of seclusion or restraint ordered by the physician, psychologist, medical psychologist, or psychiatric mental health nurse practitioner the patient shall be released unless a renewal order is issued.
(9) Mechanical restraints shall be designed and used so as not to cause physical injury to the patient and so as to cause the least possible discomfort.
(10) Facilities using seclusion or restraint shall have written policies concerning their use in place before they can be used. These policies shall include standards and procedures for placing a patient in seclusion or restraint, and for informing him of the reason he was put in seclusion or restraint and the means of terminating such seclusion or restraint.
(11) Nothing in this Section shall be construed to expand the scope of practice of psychology as defined in R.S. 37:2351 et seq. to authorize the ordering, administering, or dispensing of medications, or to authorize any practice not permitted under the privileges granted by the institution.
(12) The department shall adopt rules and regulations in accordance with the Administrative Procedure Act to govern the use of seclusion and restraint. Such rules and regulations shall respect the patient's individual rights, protect the patient's health, safety, and welfare, and be the least restrictive of the patient's liberty. The department shall adopt rules and regulations to provide for enforcement procedures and penalties applicable to a person who violates the requirements of this Section.

E. A patient may be placed alone in a room or other area pursuant to behavior shaping techniques such as "time-out". Such confinement may only be used as part of a written treatment plan, shall not be used for the convenience of staff, and may be used only according to the following standards and procedures:
(1) Placement alone in a room or other area shall be imposed only when less restrictive measures are inadequate.

(2) Placement alone in a room or other area shall only be ordered by a qualified professional trained in behavior-shaping techniques and authorized in accordance with the written policies and procedures of the facility to order the use of behavioral-shaping techniques.
(3) The period of placement alone in a room or other area shall not exceed thirty minutes.
(4) The patient shall be observed and supervised by a staff member.
(5) The period of placement alone in a room or other area shall not exceed a total of three hours in any twenty-four-hour time period. If the placement alone in a room or other area exceeds a total of three hours in any twenty-four-hour time period, it shall then be considered seclusion and shall be governed by the procedures and standards set forth in Subsection D of this Section.
(6) The date, time, and duration of the placement shall be documented.
(7) In treatment facilities where patients are placed alone in a room or other area as a behavior-shaping technique, there shall be written policies and procedures governing use of such behavior-shaping technique.

F. No patient confined by emergency certificate, judicial commitment, or non-contested status shall receive major surgical procedures or electroshock therapy without the written consent of a court of competent jurisdiction after a hearing. If the director of the treatment facility, in consultation with two physicians, determines that the condition of such a patient is of such a critical nature that it may be life threatening unless major surgical procedures or electroshock therapy are administered, such emergency measures may be performed without the consent otherwise provided for in this Section. No physician shall be liable for a good faith determination that a medical emergency exists.

G. Every patient shall have the right to wear his own clothes; to keep and use his personal possessions, including toilet articles, unless determined by a physician, medical psychologist, or psychiatric mental health nurse practitioner that these are medically inappropriate and the reasons therefor are documented in his medical record. The patient shall also be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases, and to have access to individual storage spaces for his private use. If the patient is financially unable to provide these articles for himself, the treatment facility shall provide a reasonable supply of clothing and toiletries.

H. Every patient shall have the right to be employed at a useful occupation depending upon his condition and available facilities.

I. Every patient shall have the right to sell the products of his personal skill and labor at the discretion of the director of the treatment facility and to keep or spend the proceeds thereof or to send them to his family.

J. Every patient shall have the right to be discharged from a treatment facility when his condition has changed or improved to the extent that confinement and treatment at the treatment facility are no longer required. The director of the treatment facility shall have the authority to discharge a patient admitted by judicial commitment without the approval of the court which committed him to the treatment facility. The court shall be advised of any such discharge. The director shall not be legally responsible to any person for the subsequent acts or behavior of a patient discharged by him in good faith.

K. Every patient shall have the right to engage a private attorney. If a patient is indigent, he shall be provided an attorney by the mental health advocacy service, if he so requests. The attorneys provided by the mental health advocacy service or appointed by a court shall be interested in and qualified by training and/or experience in the field of mental health statutes and jurisprudence.

L. Every patient shall have the right to request an informal court hearing to be held at the discretion of the court within five days of the receipt of the request by the court. If the court determines that a hearing is appropriate and if the patient is not represented by an attorney of his own or from the mental health advocacy service, the court shall appoint an attorney to represent the patient. The purpose of the hearing shall be to determine whether or not the patient should be discharged from the treatment facility or transferred to a less restrictive and medically suitable treatment facility.

M. No provision hereof shall abridge or diminish the right of any patient to avail himself of the right of habeas corpus at any time.

N. Every patient shall have the right to be visited and examined at his own expense by a physician, psychologist, medical psychologist, or a psychiatric mental health nurse practitioner designated by him or a member of his family or an interested party. The physician, psychologist, medical psychologist, or psychiatric mental health nurse practitioner may consult and confer with the medical staff of the treatment facility and have the benefit of all information contained in the patient's medical record.

O. Prefrontal lobotomy shall be prohibited as a treatment solely for mental or emotional illness.

P. No medication may be administered to a patient pursuant to the provisions of this Chapter except upon the order of a physician, medical psychologist, or psychiatric mental health nurse practitioner. The physician, medical psychologist, or psychiatric mental health nurse practitioner is responsible for all medications which he has ordered and which are administered to a patient. A record of medications administered to each patient shall be kept in his medical record including all instances when a patient is administered medication without his consent. Medication shall not be used for nonmedical reasons such as punishment or for convenience of the staff.

Q. A person admitted to a treatment facility has the right to an individualized treatment plan and periodic review to determine his progress. The appropriate staff of the facility shall review the person's progress at least at intervals of thirty days. The staff shall enter into the person's medical record his response to medical treatment, his current mental status, and specific reasons why continued treatment is necessary in the current setting or whether a treatment facility is available which is medically suitable and less restrictive of the patient's liberty.

R. A person admitted to a treatment facility has the right to have available such treatment as is medically appropriate to his condition. Should the treatment facility be unable to provide an active and appropriate medical treatment program, the patient shall be discharged.

S. Any patient known by a director of a treatment facility to be practicing a well-recognized religious method of healing under the care of a duly accredited practitioner thereof shall not be ordered medically treated, unless he is, as a result of a mental disorder, a danger to himself or to others.

Further Conditions of Which Patient is to be informed:
(Pursuant to LA Revised Statutes 28: Sec 53, Sec 55)

Statute 28: Section 53: Subsection I – Emergency Certificate
Every patient admitted by emergency certificate shall be informed in writing at the time of his admission of the procedures of requesting release from the treatment facility, the availability of counsel, information about the mental health advocacy service, the rights enumerated in R.S. 28:171 and the rules and regulations applicable to or concerning his conduct while a patient in the treatment facility. If the person is illiterate or does not read or understand English, appropriate provisions should be made to supply him this information. In addition, a copy of the information mentioned in this Subsection must be posted in any area where patients are confined and treated.
Statute 28: Section 55: Subsection H – Judicial Hearings
Every patient admitted by judicial commitment shall be informed in writing at the time of admission of the procedures for requesting release from the treatment facility, the availability of counsel, information about the mental health advocacy service, the rights enumerated in R.S. 28:171, and the rules and regulations applicable to or concerning his conduct while a patient in the treatment facility. If the person is illiterate or does not read or understand English, appropriate provisions should be made to supply him this information. In addition, a copy of the information listed in this Subsection must be posted in any area where patients are confined and treated.
For information regarding *Rights of Minor Patients*, please review Louisiana Children's Code, Article 1409.