Outpatient Services

CLIENT INFORMATION FACE SHEET

Service Provider Name: _____ Current Service:_____
Service Provider Phone#: _____

Client Name: _____ Record #:_____
Address: _____
DOB:_____ Social Security Number: _____

(COPY OF INSURANCE CARD REQUIRED IN ORDER TO RECEIVE SERVICES)

Insurance Name: _____Insurance Number:_____
Admission Date:_____ Discharge Date: _____
Race:_____ Gender circle one: Male Female
Marital Status: _____
Allergies: _____
_____
Current Medications Prescribed and over the counter: _____
_____
_____
Previous Diagnosis (DSM-ICD-9) _____
_____
_____
Current Diagnosis (DSM-ICD-9) _____
_____
_____
Last or most current GAF: _____

Who to contact in emergency situation:
Name: _____ Relationship: _____
Address: _____
Home Phone: _____Work Phone: _____
Pager: _____ Cellular: _____

Physician Name: _____ Telephone: _____
Address:_____

Case Manager/Facility:_____ Telephone: _____
Address: _____

Court Counselor: _____ Telephone: _____
Address: _____

Social Worker: _____ Telephone: _____
Address: _____

Medical Problems: _____
_____
Guardian Signature: _____ or Representative Signature: _____

Name of person completing form Print Name: _____
EOL Staff receiving this form Print Name: _____

Request for Admission and Consent for Treatment Services
Service Type:_____

I_____, (legal guardian/parent), do hereby request the admission of _____ (client) to Envisions of Life, LLC (EOL). I voluntarily consent for the above name Client to receive the service type listed above, including routine diagnostic and treatment procedures which the treatment team considers necessary and appropriate. I understand that the care provided by EOL may include, but is not limited to the use of psychotherapeutic interventions and techniques, behavior modification procedures, psycho educational activities, recreational activities, and administrations of psychotropic and/or regular medications. I understand that the staff may exercise the necessary physical restraint to protect the client and/or others if the Client's behavior places him/her or others in apparent danger, and/or if there is a need to prevent significant property damage from occurring. Interventions including therapeutic holding and elective time-out may be used if deemed appropriate by the treatment team. I understand that restrictive interventions including mechanical restraint, locked seclusion, isolation time-out and corporal punishment will not be utilized. If restrictions of client's rights will be utilized as a part of treatment, the following should be discussed with the client, and legal guardian (if applicable), upon agreement of utilization of restrictions 1. Purpose, goals and reinforcement structure of any behavior management system that is allowed 2. Potential use of restrictions of rights._____ 3. Notification procedures for use of restrictions of rights. _____also understand that if the treatment team, in consultation with a physician, deems the client severely dangerous to self and/or others, they may petition for involuntary commitment to a psychiatric hospital.

I authorized Envisions of Life staff to seek routine and/or emergency medical or dental care in the event the client becomes ill or has an accident while participating in services. This shall include emergency first aid by authorized personnel of the agency. I further understand that I will assume financial responsibility for any necessary medical care, including payment of physician, emergency room, rescue unit charge, and other supplies, which are recommended by a physician for the client.

I am aware that the practice of psychotherapy and behavior medication is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examination or treatment in the program listed above. I have been informed of the possible risks and benefits of treatment provided at Envisions of Life, LLC program. Possible risks include, but are not limited to the failure to achieve the positive outcomes that are anticipated. Benefits include, but are not limited to, the emotional and interpersonal growth of the client.

I acknowledge that treatment may include field trips or other activities away from the agency. I give permission for Envisions of Life, LLC to provide transportation to and from field trips, community agencies, therapy, private physicians, school, etc. Envisions of Life will be held harmless in case of accident or injury to the client while participating in transportation. If this is a minor, all travel outside of North Carolina will require staff to notify the legally responsible person for approval. All staff will maintain valid driver's license & vehicle insurance for personal vehicles. All company vehicles will maintain proper insurance.

I understand that Envisions of Life, LLC maintains confidential information about the clients and will not release such information about the above named Client without written consent of the legal guardian/parent or the Client after she/he becomes of legal age. Exceptions of the law are made only for special conditions such as medical emergencies. I agree for limited demographic data about the Client to be used for statistical and program planning purposes. I understand that I may object in writing to inspection of the Client's records by the North Carolina Department of Human Resources and thereby prohibit such inspection.

I have received a copy of the Client Rights, Notice of Privacy Practices, and Consumer Handbook, which includes a summary of my rights, which can be found at http://cvbh.org/PDFs/NCconsumerhandbook.pdf. I acknowledge that I have been provided information regarding benefits and risk, program policies and rules; fee practices and grievance procedures have been explained to me. If an emergency occurs After Hours I can call _____ for assistance.

I have reviewed this document and fully understand it and the doctrine of informed consent. I understand that this consent expires twelve (12) months from the signing date or at the discharge of the above named client.

_____	_____	_____
Parent/Legal Guardian	Relationship to Representative	Date
_____	_____	_____
Witness	Consumer	Consumer ID#

Disclosure of Health Information

This form implements the requirements for patient authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164; 42 C.F.R. Part 2; G.S. 122C. Except as otherwise permitted or required b the privacy law, a health care provider subject to the privacy law may not use or disclose protected health information without an authorization that complies with the requirements of 45 C.F.R. & 164.508(c).

Client Name: _____ DOB: _____ Record #: _____

I am either the consumer named above or the consumer's legally authorized representative. This form is used to obtain, or release PHI *(Protected Health Information)*

By signing this form, I authorize ENVISIONS OF LIFE, LLC to:			
Release and/or Disclose to:	Service Provider Name (_____)	**Receive From:**	Service Provider Name (_____)
Agency/Person		**Agency/Person**	
Address:		**Address:**	***SAME AS RELEASE TO***
Phone:		**Phone:**	
Person or class of persons to whom use or disclosure would be made		*Person or class of persons authorized to use or disclose information*	

Please check or list specific information to be released:

☐ Medical Information	☐ Medications	☐ TX Plans/PCP	☐ *Legal*	☐ *Progress Notes*	☐ Educational
☐ Assessments/Evaluations	☐ Financials	☐ Insurance Info	☐ Other		
☐ Other			☐ Other		

The purpose of the information is to:	

I understand that the health information used and disclosed may include information such as HIV infection, AIDS-related conditions, alcohol abuse, drug abuse, and psychological or psychiatric conditions. HIV/AIDS I authorize release of information regarding HIV or AIDS- related conditions Yes ☐ No ☐ Initials: _____

EXPIRATION OF DISCLOSURE OF HEALTH INFORMATION

I understand that once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be redisclosed by the person or agency that receives it.

This authorization expires automatically upon 90 days for a single release☐ or One year for an ongoing release☐, which is _____

Date of expiration

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protection health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. Our notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION – Sign below ONLY if you are revoking your Authorization to disclosure

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing or by notifying the assigned Envisions of Life, LLC staff to complete the revocation section of this form.

Signature of Authorized Representative: _____Print Name: _____Date of Revocation: _____

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand the ENVISIONS OF LIFE, LLC cannot deny or refuse to provide treatment, payment, and enrollment in a health plan, or eligibility for benefits on my refusal to sign.

SIGNATURES

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS AUTHORIZATION FORM

Signature of Consumer & Date: _____ Print Name: _____

OR

Signature of Authorized Representative & Date: _____

Print Name: _____

Please explain Representative's authority to act on behalf of the Consumer:_____

Rev 12/8/08, 2/26/09,11/11

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Release and/or Disclose to:	Local Management Entity (LME) ( )	**Receive From:**	Local Management Entity (LME) ( )
Agency/Person		**Agency/Person**	
Address:		**Address:**	***SAME AS RELEASE TO***
Phone:		**Phone:**	
Person or class of persons to whom use or disclosure would be made		*Person or class of persons authorized to use or disclose information*	

Please check or list specific information to be released:

☐ Medical Information	☐ Medications	☐ TX Plans/PCP	☐ *Legal*	☐ *Progress Notes*	☐ Educational
☐ Assessments/Evaluations	☐ Financials	☐ Insurance Info	☐ Other		
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Rev 12/8/08, 2/26/09,11/11

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Agency/Person		**Agency/Person**	
Address:		**Address:**	***SAME AS RELEASE TO***
Phone:		**Phone:**	
Person or class of persons to whom use or disclosure would be made		*Person or class of persons authorized to use or disclose information*	

Please check or list specific information to be released:

☐ Medical Information	☐ Medications	☐ TX Plans/PCP	☐ *Legal*	☐ *Progress Notes*	☐ Educational
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Signature of Consumer & Date: _____ Print Name: _____

OR

Signature of Authorized Representative & Date: _____

Print Name: _____

Please explain Representative's authority to act on behalf of the Consumer:_____

Rev 12/8/08, 2/26/09,11/11

307 S. Swing Rd Ste 5
Greensboro, NC 27409
Office #: 336.887.0708
Fax #: 336.887.1085

TO BE COMPLETED ON EACH VISIT BY THE PROVIDER

We expect for Medicare or Medicaid will pay for the services that you are receiving today of a/an_____. In the event that services are not paid by Medicare or Medicaid Envisions of Life, LLC expects full payment of services rendered for your client _____ within 30 days of notification.

Signature of Provider:_____

Print Name: _____Date:_____