Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

□ New Case
□ Update

□ Outpatient Therapy
□ Medication Management
□ MAT
□ Peer Support Service

Fernandez Community Center, LLC

Intake & Client Policy Forms

Admission Date: _____ Discharge Date: _____

Client Legal Name:_____ Date of Birth:_____ MR#:_____

Home Address:_____

City: _____ State:_____ Zip: _____

Home #:_____ Cell #: _____ E-mail:_____

Insurance #:_____SS#:_____

Family Information

Guardian Name:_____ Relationship: _____

Address:_____

City: _____ State:_____ Zip: _____

Home #:_____ Cell #:_____ E-mail:_____

Referral Information

Referral Source:_____ Phone #:_____

Medical Information

PCP:_____ Phone #:_____

Medical Conditions:_____

List any medication routinely taken:_____

Additional Service Providers

School: _____ Phone #: _____

DSS Social Worker:_____ Phone #: _____

Legal/DJJ: _____ Phone #: _____

Diagnostic Information

Code	Description
_____	_____
_____	_____
_____	_____
_____	_____
Allergies/Medical	_____

8376 Six Forks Rd. Suite 104
Raleigh, NC 27615
(919) 900-7438

Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

Fernandez Community Center, LLC

Consent for Treatment:

I,_____at this moment, give my consent for Fernandez Community Center, LLC to provide mental health services to me/my child. I have been informed of the scope and purpose of the service and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time. I can request my or my child's treatment plan at any time from our therapist, operations director or executive director.

Freedom of Choice:
This is to verify that I have been offered a choice of treatment and/or recovery support providers. I have chosen the provider that I feel is most likely to be accessible and supportive of my treatment and recovery. By signing below, I hereby verify I choose to receive treatment from Fernandez Community Center, LLC.

Financial Agreement:
Assignment of Insurance Benefits: I hereby authorize direct payment of my insurance benefits to Fernandez Community Center, LLC for services rendered to my dependent(s) or to me by the physician or a clinician under his/her supervision. I authorize the release of any of my or my dependent's records to secure payment. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-payments, co-insurance, deductibles or balances due that are my responsibility for payment either at the time of service or after being notified that Fernandez Community Center, LLC is unable to collect from my insurance carrier for whatever reason.

Medicaid and Medicare Insurance Benefits: I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request to secure payment. I understand that regulations pertaining to Medicare and Medicaid assignment of benefits apply. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Fernandez Community Center, LLC on my behalf.

Self-pay: I understand that Fernandez Community Center, LLC requires payment in full at the time of the service.

Cancellation or Missed Appointment Policy:
We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps Fernandez Community Center, LLC operating at it's most efficient level. Appointments not canceled within 24 hours of the visit or failure to appear for 3 appointments in a period of 12 months may result in no longer being able to provide treatment for you. We provide reminder calls before your appointments as a courtesy, but not receiving a reminder call does not excuse a missed appointment. You are responsible for remembering your scheduled appointment. I, the undersigned, have been informed about Fernandez Community Center, LLC cancellation and missed appointment policy.

Permission to Transport:
I, the undersigned, grant permission for Fernandez Community Center, LLC to provide transportation, in case of life-threatening emergency, for me/my child, and agree to hold Fernandez Community Center, LLC harmless for any accident/injury that results from the provision of transportation.

My signature indicates agreement with the terms and conditions stated above.

_____ _____
Client's Signature (required for SA) *Date*

_____ _____ _____
Parent/Guardian's Signature *Relationship* *Date*

_____ _____
Witness *Date*

8376 Six Forks Rd. Suite 104
Raleigh, NC 27615
(919) 900-7438

Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

Fernandez Community Center, LLC

Authorization to Mail, Call or Email:
I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize Fernandez Community Center, LLC representative or my provider to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, laboratory results, or financial information regarding my services, including insurance claims. I understand that I have the right to rescind this authorization at any time by notifying Fernandez Community Center, LLC to that effect in writing.

Permission to Seek Medical Care:
I hereby give consent for a Fernandez Community Center provider to seek and sign consent for emergency medical care in the event that I am unable to do so for myself or my dependent. It is understood that the Fernandez Community Services provider will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Emergency Contact:_____ Relationship:_____Phone #:_____

Preferred Hospital/PCP:_____Phone #:_____

Acknowledgement of Access to 24-Hour Coverage Emergency Number:
I have received the Acknowledgement of Access to 24-Hour Coverage Emergency Number. These include office hours: office contact, after hours contact, crisis centers and the Governor's Advocacy Council for Persons with Disabilities (GACPD), the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities. A Fernandez Community Center provider gave me this handout and verbally explained how to use the system in the event of a mental health emergency or crisis. I understand this system is available to me/my child while receiving Fernandez Community Center and a Crisis Plan, if necessary, will be developed as part of my/my child's Treatment Plan.

Discontinuation of Treatment Policy:
Please be aware that Fernandez Community Center, LLC may discontinue my, or my child's treatment for any of the following reasons:

1. Achievement of treatment goals
2. Failure to appear for three appointments in a period of 12 months.
3. Being consistently late for appointments or consistently cancelling appointments (3) without at least a 24-hour notification
4. Not participating in treatment for a period of 30 consecutive days.

I, the undersigned, have been informed and received a copy of Fernandez Community Center, LLC discontinuation of treatment policy.

My signature indicates agreement with the terms and conditions stated above.

_____ _____
Client's Signature (required for SA) *Date*

_____ _____ _____
Parent/Guardian's Signature *Relationship* *Date*

_____ _____
Witness *Date*

8376 Six Forks Rd. Suite 104
Raleigh, NC 27615
(919) 900-7438

Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

Fernandez Community Center, LLC

Consent to Retrieve Prescription History:
I hereby consent to retrieval of my or my dependent's prescription history from external sources such as control substance reporting database. This information is used to ensure the safety and accuracy of my or my dependent's prescription service and to coordinate care with other providers.

Laboratory Testing
I consent to the collection of a specimen and drug testing analysis. I authorized Fernandez Community Center, LLC to send the specimens to outside laboratories for analysis. I understand that Fernandez Community Center, LLC uses one of these outside labs: _____. I authorize Fernandez Community Center, LLC to release and exchange protected health information (PHI) with the aforementioned laboratory. I certified that I will not adulterate any samples in any manner and that information provided on this form and on all future labels attached to the specimen cup are correct. Refusal to comply with toxicology screening can negatively affect the physician's ability to diagnose, develop treatment plan and/or prescribed medication.

Laboratory Fees For Commercial/Private Health Insurance:
I understand that I am paying $35.00 for my toxicology screening. I also understand the physician will determine whether an urine confirmation test is needed. In the event an urine confirmation is needed, it is my responsibility to check with my insurance company to see if the outside lab services are covered under my plan. I understand that I may receive a separate bill if my medical care includes lab or other diagnostic services from another facility. I understand that outside labs are not associated with Fernandez Community Center, LLC.I further understand that, I am financially responsible for any co-payment, co-insurance, deductible, or other balance due for these services if they are not reimbursed by my insurance for whatever reason.

My signature indicates agreement with the terms and conditions stated above.

_____ _____
Client's Signature (required for SA) *Date*

_____ _____ _____
Parent/Guardian's Signature *Relationship* *Date*

_____ _____
Witness *Date*

8376 Six Forks Rd. Suite 104
Raleigh, NC 27615
(919) 900-7438

Client Full Name: _____ DOB:_____ Insurance #: _____MR#_____

Fernandez Community Center, LLC

Telehealth Consent

Telehealth is the use of electronic transmissions to treat the needs of a patient. In this case, we offer both video and audio forms of communication via the Internet and/or telephone. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications, may occur from different locations geographically in order to assist with delivery of care when access to care may not be possible by face-to-face visits.

I understand that Teletherapy occurs in the state of North Carolina, and is governed by the laws of the state where the client resides. Teletherapy may also be governed by the laws of the state in which the providers are located at the time of service delivery if that state is other than NC. All providers are licensed in the states in which you reside, as well as the state the provider may be located in at the time of a Teletherapy session.

While Teletherapy is an effective way to obtain assistance when geographic distance or scheduling conflicts prevent face to face care, in the event that Teletherapy is determined to not be in your best interests, your provider will explain that to you and suggest some alternative options better suited to your needs. In most cases, this will likely include a recommendation for face-to-face psychiatric consultation or psychotherapy or a referral to a facility or an agency that may provide a higher level of care. Teletherapy is not intended for emergency services, and if emergencies arise you will be required to seek face to face consultation and evaluation, and by signing this consent, you agree in advance to seek such care if you or your provider deem this necessary. In the event of an imminent emergency, clients should consult the nearest emergency room or psychiatric facility to provide emergent care.

You are responsible for information security on your computer. If you decide to keep copies of our emails or other communication on your computer, it's up to you to keep that information secure. Unfortunately, we cannot guarantee the security of emails as they travel between computers. It is possible, though unlikely, to intercept emails in transit.

Teletherapy may be received either from your chosen environment (e.g., home or work) or from another location of your choice. You understand that you are responsible for (1) providing the necessary computer, telecommunications equipment and internet access for Teletherapy sessions; (2) the information security on your computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions and intrusions, and sufficient for privacy to protect your personal health information.

I understand that there are risks and consequences from Teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. Other risks include Viruses, Trojans, and other involuntary intrusions that have the ability to grab and release information you may desire to keep private. Furthermore, with Teletherapy, there is the risk of being overheard by anyone near you if you do not place yourself in a private area and protected from other's intrusion. You maintain sole responsibility for ensuring the privacy of your surroundings if participating in Teletherapy. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy and that despite my provider's efforts, my condition may not improve, and in some rare cases may even get worse.

Consent to Contact and Electronic Transmittal

I give my consent for the Fernandez Community Center to send by electronic transmittal (fax or email) or communicate by cellular phone, with appropriate release of information, confidential information concerning my or my child's diagnosis, care, testing records, treatment plan and goals. I have the right to revoke this authorization at any time. Revocation is not effective in cases where the information has already been disclosed but will be effective in moving forward.

I understand the Fernandez Community Center will exercise all reasonable precautions and I will in no way hold the Agency liable for any difficulties resulting in me or any other family member from the communication of confidential information by means of cellular phone, fax, email or web-based scheduling systems. I have the right to refuse to sign this authorization.

By signing this form indicate that you and/or your representative have read, understand and are in agreement with the terms and

conditions of this agreement, including the following:

- You are the person that can provide this legal consent
- You have read this agreement and agree to its terms
- You acknowledge that you have received the HIPAA Privacy Policy and Clients Rights and Responsibilities documents You have had the opportunity to ask any questions that you may have related to this agreement

_____ _____

Client's Signature (required for SA) *Date*

_____ _____ _____

Parent/Guardian's Signature *Relationship* *Date*

_____ _____

Witness *Date*

Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

Fernandez Community Center, LLC

Notice of Privacy Practices & Client Rights

As a consumer at Fernandez Community Center you are entitled to certain rights while receiving services. We are required by law to protect your medical and personal information as well as information which may identify you. Information may include details about the health care that we are providing for you, payment for services, or information about your past, present, or future health concerns. By law, we are required to provide you with this Notice of Privacy Practices that explains our requirements and limitations in regard to protecting your personal information. We will also provide you with a copy of our Consumer Policies, which outline our expectations and your responsibilities while receiving services from Fernandez Community Center. We reserve the right to make changes to the terms in these policies in the future and will inform you promptly of such changes. We will post the changes in the facility and have copies of the new policies available at your request.

You have a right to a copy of this notice and a copy of our Consumer Policies at any time. In addition, a copy of this notice will be posted in our facility. Please feel free to ask a staff member for a copy of this notice when necessary. We may use and disclose health information about you in order to provide accurate and effective services for you including coordinating health care interventions for you, in developing treatment goals with vested parties, and monitoring successes and progress. Case managers, therapists, guardians, and physicians are included as members of the treatment team and your health information may be shared between team members.

We may use and disclose health information about you to insurance companies in order to obtain payment for services we provide. We may also disclose information before services are provided in order to obtain permission to provide certain interventions or services. Please be aware that any personal health information or diagnosis may be provided to an insurance company and may well become part of your permanent insurance record. We will use and disclose health information when we are required to do so by law. There are many state and federal laws that require facilities to report gunshot wounds and suspected abuse or neglect. We will report personal health information in other cases including but not limited to:

1. We believe you to be a danger to yourself or someone else;
2. You give us written permission to disclose information to other parties;
3. In the case of abuse to a child or an elderly person, your confidentiality will be waived;
4. If information is court ordered;
5. If you want to seek reimbursement from a managed care company, the disclosure of confidential information may be required for reimbursement;
6. In case of a Medical Emergency;
7. Confidentiality rights are waived if accusations of misconduct are brought against you or us;
8. If we need to report information related to investigating diseases or monitoring drugs or medications monitored by the Food and Drug Administration;
9. Information may be released to a health oversight organization which is responsible for overseeing health care facilities and government programs;
10. We may use or disclose information to certain government departments including military and veterans' activities, national security and intelligence agencies, and correctional institutions.

In order to protect personal information to the best of our ability you will be asked to sign and date an authorization to treat consent form and an authorization for the disclosure and reciprocal exchange of information contained in this packet. You will be given the opportunity to choose what information will be released. Signing these consent forms does not guarantee that personal health information will be kept confidential, as is outlined in the section above.

You have been informed of the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability, as cited in, General Statutes 122C-51 Declaration of policy on clients' rights. It is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. FCC commits to assure each client the right to live as normally as possible while receiving care and treatment. It is further the policy of this State that each client who is admitted to and is receiving services from FCC has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse.

Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

Fernandez Community Center, LLC

Notice of Privacy Practices & Client Rights (Continued)

While receiving services from Fernandez Community Center, you are responsible for being an active member of the treatment team by investing in the development and progress of your plan. You are welcome to request copy of your treatment plan at any time, during your treatment. Please request from your therapist, the Operations Director or the Executive Director. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities.

If the rules and code of conduct is violated, a member of the staff will address you personally. When necessary, meetings may be arranged for interested parties to attend and discuss changes in goals and interventions. It is the expectation of the staff at Fernandez Community Center that you contribute to the success of your person-centered plan by providing the team with feedback and suggestions as well as putting forth the effort to achieve the identified goals. Consequences for disregarding these expectations may include but are not limited to suspension or discharge from the program.

Thank you for reviewing the policies of Fernandez Community Center. By signing the following form, you acknowledge that you have received a copy of the policies and understand their contents. We look forward to this opportunity to work and grow together.

I hereby acknowledge I have been provided a copy, and had the opportunity to read Fernandez Community Center, LLC Notice of Privacy Practices and Client Rights. I understand that if I have any questions regarding my privacy and client rights, I can discuss this with my provider. I have been educated on how identifiable health information may be used and disclosed. I understand that this notice also informs me of my rights in regard to my protected information.

_____ _____

Client's Signature (required for SA) *Date*

_____ _____ _____

Parent/Guardian's Signature *Relationship* *Date*

_____ _____

Witness *Date*

8376 Six Forks Rd. Suite 104
Raleigh, NC 27615
(919) 900-7438

Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

Fernandez Community Center, LLC

Authorization for Release of Information and Reciprocal Exchange of Information

Individual Name:_____ DOB:_____
MR#: _____ Insurance #: _____

I Authorize, Fernandez Community Center, LLC **to obtain records from or release records to:**

Person/Agency:_____ Phone #: _____
Address:_____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Type of information released:

☐ Psychiatric Evaluations
☐ Treatment Plan/Diagnosis
☐ Discharge Summaries
☐ Progress /Psychotherapy Notes
☐ Other:
☐ Mental Health Clinical Assessment
☐ Medical Reports/Medical History
☐ Medications
☐ Lab Results
☐ Psychological Evaluation
☐ Court/Legal
☐ Insurance Information
☐ Educational Records

Specific Authorization for Release of Information Protected by State/Federal Law:

☐ Substance abuse (alcohol/drug use) Treatment ☐ HIV/AIDS information

I understand the purpose of the disclosure/redisclosure will be used for:

☐ Assist with / coordination of treatment ☐ At request of client ☐ Referral
☐ Other: _____

My signature below indicates that I understand what information will be released and the need for the information. I understand that Fernandez Community Center, LLC has not conditioned my treatment on signing this authorization and that I may refuse to sign this authorization if I so desire. I further understand that the information to be released may include information regarding drug and alcohol abuse or AIDS/HIV. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the HIPPAA federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient 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. I understand that I retain the right to revoke this Authorization in writing, at any time, except to the extent that the agency has already acted in reliance on the Authorization.

This consent will expire_____ (*specific date or condition)* not more than 365 days from the date of signature.

I have read this information and understand that statutes and regulations are protecting the confidentiality of authorized information. I at this moment acknowledge that this authorization is truly voluntary and that I am the protected client or am authorized to act on behalf of the client to sign this document. I fully agree with the above stated terms. I understand that I may request a copy of this authorization once it has been signed.

_____ _____
Client's Signature (required for SA) *Date*

_____ _____ _____
Parent/Guardian's Signature *Relationship* *Date*

_____ _____
Witness *Date*

8376 Six Forks Rd. Suite 104
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Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

Fernandez Community Center, LLC

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☐ Court/Legal
☐ Insurance Information
☐ Educational Records

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Client's Signature (required for SA) *Date*

_____ _____ _____
Parent/Guardian's Signature *Relationship* *Date*

_____ _____
Witness *Date*

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Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

Fernandez Community Center, LLC

Authorization for Release of Information and Reciprocal Exchange of Information

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☐ Discharge Summaries
☐ Progress /Psychotherapy Notes
☐ Other:
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☐ Psychological Evaluation
☐ Court/Legal
☐ Insurance Information
☐ Educational Records

Specific Authorization for Release of Information Protected by State/Federal Law:

☐ Substance abuse (alcohol/drug use) Treatment ☐ HIV/AIDS information

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☐ Assist with / coordination of treatment ☐ At request of client ☐ Referral
☐ Other: _____

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_____ _____
Client's Signature (required for SA) *Date*

_____ _____ _____
Parent/Guardian's Signature *Relationship* *Date*

_____ _____
Witness *Date*

8376 Six Forks Rd. Suite 104
Raleigh, NC 27615
(919) 900-7438

Client Full Name:_____ DOB:_____ Insurance#_____MR # _____

Fernandez Community Center, LLC

Consents Overview
Revision General de Consetimientos

I understand that I have signed the following consents/Yo entiendo que he firmado los siguientes consentimientos:

1. Consent for treatment/Consentimiento de Tratamiento
2. Freedom of Choice/ Libertad de Elección
3. Financial Agreement/ Acuerdo Financiero
4. Cancelation or Missed Appointment Policy/ Cancelación o Poliza de Citas Perdidas
5. Permission to Transport/Permiso para Transportar
6. Permission to Mail, Call, or Email/ Permiso para Correo, LLamada o Correo Electrónico
7. Permission to seek Emergency Medical Care/Permiso para Buscar Atencion Medica de Emergencia
8. Acknowledgement of Access to 24-hour coverage emergency number/ Confirmación de acceso al número de emergencia de cobertura las 24 horas
9. Acknowledgement of Criteria and Procedures for Discharge/ Reconocimiento de Criterios y Procedimientos de Alta.
10. Discontinuation of Treatment Policy/ Póliza de Descontinuación de tratamiento
11. Consent to Retrieve Prescription History/ Consentimiento para Obtener el Historial de Prescripción Medica.
12. Laboratory Testing/ Pruebas de Laboratorio
13. Laboratory Fees for Commercial/Private Health Insurance/ Cuotas de Laboratorio para Seguros de Salud Comerciales / Privados

I have been informed of /Me han informado sobre:

1. Privacy Rights/Derechos de Privacidad

I have had input in my/my child's Clinical Assessment and Treatment Plan/ Yo he contribuido en la Evaluacion Clinica y Plan de Tratamiento mia /mi hijo/a.

I have agreed that Fernandez Community, LLC center may release obtain information from/ Yo estoy en acuerdo de que Fernandez Community Center, LLC puede liberar/obtener información de:

1._____

2._____

3._____

4._____

_____ _____
Client's Signature (required for SA) *Date*

_____ _____ _____
Parent/Guardian's Signature *Relationship* *Date*

_____ _____
Witness *Date*

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