*5673 Airport Road, Roanoke VA 24012* *Client Number:* *\_*

*Phone: 540-523-8080 opt 1*

*Fax: 540-512-9775*  *Admission Date:* *\_*

[*truenorthreferrals@intercepthealth.com*](mailto:truenorthreferrals@intercepthealth.com)

|  |  |  |  |
| --- | --- | --- | --- |
| *Service (s) That Client is Inquiring About:*  Substance Abuse Services  Psychiatric Services | | *Does Client have Internet Capability:*  Yes  What Device:  Cell Phone,  Laptop/Computer  Tablet  No | |
| **Patient Name:** | | **Parent/Legal Guardian Name:** | |
| Patient DOB: | Age: | Email for Appointment reminders and Correspondence | |
| Home Phone: | Work Phone: | | Cell Phone: |
| Street Address: | City: | | Zip: |
| **Is the above Address the same Address to use to for Billing?**  Yes  If No, What Address should we use? | | | |
| **Insurance Information** | | | |
| Insurance Carrier: | | Policy Number: | |
| Policy Holder Name: | | Policy Holder DOB: | |
| Relationship to Policy Holder: | | Policy Holder Phone: | |
| Who is responsible for the Account? | | | |

Emergency Medical Information

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name: | | Patient DOB: | Client Number: |
| Emergency Contact Name:  Emergency Contact Address: | | | Home Phone: |
| Cell Phone: |
| Pediatric or Primary Care Provider’s Name: | | | Office Phone: |
| Address: |
| Insurance Carrier: | | | Policy # |
| Drug or Food Allergies:  None Known  Yes:  Describe | Medical Diagnosis:  None Known  Yes:  Describe | | History of Substance Abuse:  No  Yes:  What substance(s) |
| |  |  |  | | --- | --- | --- | | Current Medications: | Dosage: | Directions for Use: | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | | | |
| Are there any Mobility Problems?  No  Yes: Describe | Are there any Sensory Problems?  No  Yes: Describe | | Are there any Communication Problems?  No  Yes: Describe |
| Are there any Dietary Concerns?  No  Yes: Describe | Do you have an Advance Directive?  No  Yes: Describe | | Is there any other information that we should know in case of an emergency?  No  Yes: Describe |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print) Date

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Patient or Parent/Legal Guardian Signature (if applicable) Date

|  |  |  |
| --- | --- | --- |
| Client Number:  Date Information was Completed: | Admission Date: | |
| **Patient Name:** | | | DOB: | Race: |
| Gender:  Male  Female | Language: | Religion: | | |
| Height: | Weight: | | |
| Legal Status:  Minor  Emancipated  Adult | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Other Mental Health or Substance Services that you are Currently Receiving** | Case Management | Mental Health Supports | Individual Counseling | Psychiatric Medication Management | Detox  Medication Management |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Services that you May be interested In at Intercept** | Case Management | Mental Health Supports | Counseling  Services | Psychiatric Medication Management | Detox  Medication Management |
| Briefly describe reason for appointment: | | | | | |
| **SAFETY INVENTORY**  Have you ever felt like hurting yourself?  Yes  No  Have you ever actually hurt yourself?  Yes  No  Do you currently feel like hurting yourself?  Yes  No  Do you have a suicide plan?  Yes  No  Have you ever felt like hurting someone?  Yes  No  Have you ever actually hurt someone else?  Yes  No  Do you currently feel like hurting someone else?  Yes  No  If yes to any of the above question(s) Please explain: | | | | | |
| **Pharmacy Information:**  Name of Pharmacy:  Location/Address of Pharmacy: | | | | | |
| **Check the Box if you would like to sign a Release of Information Today**  Primary Care Provider  Pediatric Provider  Specialist  DSS  Significant Other  Emergency Contact  Lawyer  Probation  School  Employer  Support Worker  Case Manager  Counselor  Family Member  Other  Please NOTE That Information will not be released without having a signed release on File. Releases will only be good for the period that is expressed on the form. Please ask the Front office staff/Admissions for a release of information. | | | | | |

I agree that the Above information is true and correct.

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Patient Name (please print) Date

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Patient or Parent/Legal Guardian Signature (if applicable) Date

Financial Agreement and General Consent

(Please Check the Consent or Non-Consent Box. Please filling in any Blanks)

Patient Name:  DOB:

1. **Consent to Treatment:** I hereby authorize the employees, agents and staff of Intercept Youth Services, Inc and True North Health Clinic to perform and hereby consent to such medical treatment, examinations, including diagnostic procedure, as may in the opinion of my/the patient’s physician(s) be deemed necessary and advisable. If I /the patient fails to follow the direction of the health care providers or to carry out the recommended follow up medical care, I/the patient do so at my own risk.   I Consent  I Do Not Consent
2. **Technology Based Services:** Technology Based Service Delivery for Psychiatric Assessments, Counseling and Medication Management may be provided to clients served in Intercept Programs by way of Tele Psychiatry in the state of Virginia. This approach will allow personnel to see, hear, and interact with clients from a remote location and provide services at a distance. Intercept will utilize a Tele Specialized Cloud-Based Platform that is Secure and HIPAA compliant. Prior to offering Tele Psychiatry to a specific location, readiness factors such as service population, need and staff capacity will be considered. Service locations will provide a secure private room, computer and landline phone to offer Tele Psychiatry to clients. Service locations will use equipment that is maintained by the Service Location. The Intercept Originating site will provide the Licensed Mental Health Professional and/or Medical Provider to provide the services. The Licensed Mental Health Professional and/or Medical Provider will be licensed within the State of Virginia and other governing bodies for which their license requires. The Originating site will use an Intercept owned computer to provide Tele Psychiatry services to clients. Privacy and Security measures put in place through Intercept policy will be followed. All information gathered during a Tele Psychiatry Session will be documented within a separate Electronic Medical Record platform. Intercept recognizes that not every individual will be suitable or comfortable for Tele Psychiatry and recommendations for other service providers will be made as individuals are identified. When engaging in Tele Psychiatry clients will be notified about provider credentials, location, contact information, diagnosis, medication recommendations, drug interactions, and service recommendations. Intercept Personnel will be competent in the equipment, software, privacy and confidentiality. I agree to hold harmless Intercept Health for delays in evaluation or for information lost due to such technical failures. Emergency Crisis situations will be dealt with immediately and the use of local emergency numbers and services will be utilized. I have read the above information regarding Intercept’s use of Technology Based Services and have had an opportunity to have my questions answered.  I Consent   I Do Not Consent
3. **Release of Liability:** I, (parent/guardian)  , hereby release Intercept Youth Services, Inc. and True North Health Clinic form any and all liability while the (child)  for which I am legal guardian, or myself or others allowed by us/me, are present for an appointment at Intercept Youth Services, Inc. and True North Health Clinic. I authorize and permit the administration of first aid, access to other emergency services, substance abuse services, or psychiatric services, included via Tele Medicine. I release Intercept Youth Services, Inc. and True North Health Clinic from all liabilities associated with my child being treated or seen.  I Consent  I Do Not Consent
4. **No Guarantee:** I am aware that the practice of medicine or therapy is not an exact science, and I acknowledge that no guarantees have been made as to the result of any procedures, treatments, testing, or examinations, I understand that the risks of treatment may include, but are not limited to infections.  I Consent  I Do Not Consent

1. **Aggression/Threats:** No physical and/or verbal aggression or threats will be tolerated; such actions will result in immediate discharge. Police and Emergency agencies could be notified.  I Consent  I Do Not Consent
2. **Deemed Consent for Blood Testing**: I understand that, under Virginia state law, if a health care provider, or a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consented to testing for HIV or Hepatitis B or C, and to the release of test results to the person who was exposed. For example, exposure could occur due to an accidental needle stick. Patients who have a confirmed positive rest result will be given the opportunity for individual face to face disclosure and appropriate counseling.  I Consent  I Do Not Consent
3. **Assignment of Payment:** In consideration of medical services to be rendered to me/the patient or at my/the patient’s request paid by my health insurance or liability policy or other arrangements, or plan with a third party that provides payment for medical or health care services or policy of insurance, or from any settlement or judgement that comes from any related incident that caused the medical treatment.  I Consent  I Do Not Consent
4. **Referral/Authorization and Non Covered Services:** I understand that my/the patient’s health insurance, HMO, or health benefit plan may require a referral and/or authorization, failure to properly identify my/the plan or coverage, receipt of services that authorization, failure to properly identify me/the plan or coverage, receipt of services that are not covered or for which the patient is not eligible under the plan or coverage that the services were not medically necessary. I acknowledge and agree that, in the event payment for these services is denied based on the provisions of my/the patient’s insurance HMO or health benefit plan, I am fully personally responsible for payment of charges for these services and will be billed directly.  I Consent  I Do Not Consent
5. **Promise To Pay:**  I understand that I owe and unconditionally agree to pay to Intercept Youth Services, Inc. and True North Health Clinic the full amount charged for the services rendered to myself, my child, and/or any patient for which I am legally responsible that are not paid on my/the patient’s behalf by a third party within sixty days from billing of medical services rendered. I understand that separate bills may be generated for some services. Additionally, I agree to pay my insurance co-payment, co-insurance, or known out of pocket expenses, at the time of services. I agree that, if Intercept Youth Services, Inc. and True North Health Clinic must initiate collection efforts to recover amounts owed by me, then in addition to amount incurred for the services rendered, I will pay, to the extent permitted by law: (a) any and all costs incurred by Intercept Youth Services, Inc. and True North Health Clinic in pursuing collection, including but not limited to, reasonable attorney’s fees; and (b) any court costs or other costs of litigation incurred by Intercept Youth Services, Inc. and True North Health Clinic.  I Consent  I Do Not Consent
6. **Consent to receive Email Notifications:** I hereby consent to receive emails for appointments, treatment recommendations and invoices.  I Consent  I Do Not Consent
7. **Release, Disclosure, and Use of Patient Information** **including protected health information:** I understand that Intercept Youth Services, Inc. and True North Health Clinic uses an electronic medical record. I authorize Intercept Youth Services, Inc. and True North Health Clinic to release my/the patient’s health information to any physician involved in my treatment; to any health care facility to which I/the patient is discharged or transferred for treatment; to affiliates of Intercept or other health care providers and for purposes of treatment, payment, and health care operations including but not limited to billing, healthcare management, discharge planning, quality assurance, bill collections, defense of litigation or anticipated litigation, and/or to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by Intercept Youth Services, Inc. and True North Health Clinic. I consent to the use, release and disclosure of my/the patient’s protected health information for all the above reasons. I authorize Intercept Youth Services, Inc. and True North Health Clinic to access and use my patient prescription information from any health care provider or benefits manager including prescriptions that have been submitted for claims to any insurance plan. I understand that I have a right to request restrictions on how my health information is used or disclosed for treatment, payment, and health care operations, and that Intercept’s True North Health Clinic is not required to agree to such a restriction request.  I Consent  I Do Not Consent
8. **Privacy Notice Consent**: I give Intercept Youth Services, Inc. and True North Health Clinic my consent to use or disclose my protected health information to carry out my treatment; to obtain payment from insurance companies; and for health care operations like quality assurance reviews. I have been informed that I may review Intercept Youth Services, Inc. and True North Health Clinic’s Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that Intercept Youth Services, Inc. and True North Health Clinic has the right to change their privacy practices and that I may obtain any revised notices at Intercept Youth Services, Inc. and True North Health Clinic. I understand that I have a right to request a restriction of how my protected health information is used. However, I also understand that Intercept Youth Services, Inc. and True North Health Clinic is not required to agree to the request. If Intercept Youth Services, Inc. and True North Health Clinic agrees to my requested restriction they must follow the restriction(s). I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.  I Consent  I Do Not Consent
9. **Medicare Lifetime Signature Authorization and Assignment:** I request that payment of authorized Medicare/Medicaid benefits be made on my/the patient’s behalf for any services furnished by Intercept Youth Services, Inc. and True North Health Clinic including physician services. I authorize any holder of medical or other information about me/the patient to release to the Centers for Medicare and Medicaid Services, The Virginia Department of Medical Assistance Services, and their agents, any information needed to determine these benefits for related services. I assign the benefits payable for physician and other medical services to the physician or organization to submit claims to Medicare and/or Medicaid for payment. I understand that I am responsible for any deductible, co-payments, and/or applicable amount of remaining charges.  I Consent  I Do Not Consent
10. **Consent to Wireless Telephone Call:** If any time, I provide a wireless telephone number to Intercept Youth Services, Inc. and True North Health Clinic at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages, automated appointment reminders) at that wireless number from Intercept Youth Services, Inc. and True North Health Clinic, its successors and assigns, and its affiliates, agents, and independent contractors, including collection agents, regarding the services rendered, hospitalization, and/or my related financial obligations.

I Consent  I Do Not Consent

1. **Additional Provision Applicable for Admission of Minor or other Patient for Which the Undersigned is Legally Responsible:** I, the undersigned, acknowledge and verify that I am the legal guardian, custodian, or otherwise legally responsible for the patient.  I Consent  I Do Not Consent
2. **Weapons Policy:** I understand and agree with Intercept Youth Services, Inc. and True North Health Clinic’s weapons policy-Intercept Youth Services, Inc. and True North Health Clinic will have no firearms, pellet guns, air rifles, knives, or other weapons in its main or satellites offices. Employees, contractors or student interns/volunteers will not have such weapons in their car or on their person. I agree not to bring such weapons onto the premises of any Intercept office or property.  I Consent  I Do Not Consent
3. **No Show Policy:** To assist patients who are waiting for an opening, Intercept Youth Services, Inc. and True North Health Clinic has adopted a strict late cancel and no-show policy. We may be unable to continue providing medication management services to any patient who either cancels late without a 24 hour notice or no shows 3 appointments within a calendar year. Cancellations on the day of an appointment or arriving late to your appointment are considered late cancellations. Also, we are unable to reschedule patients who miss their initial evaluation appointments. Excessive rescheduled appointments of any type within a calendar year may also be a reason for dismissal from the practice.  I Consent  I Do Not Consent
4. **Medications/Refills/Medication Adjustments:** Intercept True North Health Clinic will only prescribe medications that are within the scope of Psychiatric and Addiction Medicine. Controlled Medications will not be replaced and it is important that you keep up with the medication. Refills will only be given to active clients who have been seen on a regular basis. If you are in need a prescription refill please have your pharmacy send the request. We ask to allow 48 hours for Refills to be processed. Clients as well as Providers may request sooner appointment times to make Medication Adjustments when needed.  I Consent  I Do Not Consent
5. **Closures/Delayed Opening:** Closures and Delayed Openings may occur due to Inclement Weather or unforeseen circumstances. The Office voicemail will be updated to reflect any closures or delays whenever possible, everyone is encouraged to call the office number to hear any closures or delayed opening information. If a Refill is needed, please have your pharmacy fax over a refill request.  I Consent  I Do Not Consent
6. **Emergency and Evacuation Procedures:** Intercept uses local emergency service plans in the 911 service for any emergency that may arise on the premises during the course of treatment and/or normal treatment hours.

Written Floor Plans are posted in common areas and group rooms indicating exit patterns. The building is equipped with alarm systems for fire and other emergencies. Each staff member is responsible for the knowledge of basic emergency routines and activities. The program director, group counselor, or provider will see that all staff and clients present in the location are evacuated and accounted for and the appropriate emergency units and court services will be used whenever indicated and necessary. All staff are trained in emergency evacuation procedures as outlined by the fire department and randomly drilled. Evacuate in an orderly and calm manner towards the exit locations. All persons should remain on the premises in the parking lot area away from the building. 911 will be contacted. Document all present and keep an administrative record of the event.  I Consent  I Do Not Consent

1. **Acknowledgement:** I have read this agreement, fully understand its terms, and agree to follow and be bound by them. I certify that all information supplied by me as part of the admission/registration process is correct. By signing this form, I acknowledge that I have received the Notice of Privacy Practices.  I Consent  I Do Not Consent

I have received, read and understood the Financial Agreement, General Consent, Psychiatric Client Handbook and IOP Client Handbook (if applicable), and Suboxone Instructions (if applicable).

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Patient Name (please print) Date

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Patient or Parent/Legal Guardian Signature (if applicable) Date

Client Bill of Rights

1. You have the right to be called by name, treated with respect and dignity.
2. You have the right to confidentiality including all information in your record except when State Law requires or allows disclosure.
3. You have the right to retain all your legal rights as guaranteed by the State and Federal government.
4. You have the right to treatment and services under conditions that support your personal freedom, and limits that freedom only when necessary to provide treatment.
5. You have the right to refuse treatment that is offered at any time. You will be informed of the effects of treatment on your body and mind. You have the right to legal representation when unable to act on your own behalf.
6. You have the right to treated fairly, regardless or your race, color, religion, ethnicity, age, sex, mental health/developmental delay/substance abuse illness or disability.
7. You have the right to take part in the development of your personalized, written, treatment plan, to receive treatment based on the plan, review and re-evaluate your needs identified in the plan, periodic changes to the plan and a description of the services that may be needed for follow up.
8. You have the right to be told of other ways you can receive treatment.
9. You have the right never to be physically or verbally abused, neglected, or exploited by an employee.
10. You have the right to know if you are being recorded by video or audio tapes.
11. You have a right to refuse to be a part of any study or research project.
12. You have the right to contact and consult your attorney, your private doctor, or others of your choice at your own expense.
13. You have the right to be free from unnecessary or excessive medication. Any medication needs will be discussed with your parent or guardian and its use will be made part of an overall treatment plan.
14. You have the right to be told, in understandable language, the rights described in this document and all program expectations and rules.
15. If you believe that your rights have violated, you have the right to contact the program director at 540-523-8080 or the Regional Human Rights Advocate.
    1. Northwest-Capital Region: Cassie Purtlebaugh-804-382-3889
    2. Southwest Region: Jennifer Kovack-804-248-8043
    3. Central Region: Beverly Garnes-804-524-7479
    4. Tidewater Region: Reginald Daye- 757-253-7061

I have received, read and understood The Client Bill of Rights

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Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (if applicable) Date

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**Client Grievance Procedure**

Intercept Health is concerned with any problems you may experience with this program or any services you receive through Intercept Health. In order to fix the problems, we need to know about them. Therefore, we have set up a Client Grievance Procedure that we ask that you, your legal guardian or someone on your behalf use to help us better serve you. If you have a problem, complaint or grievance with this program or any services you are receiving through Intercept Health, or if you believe that any of your rights have been violated, please report it. The following is the procedure to let you have your problems heard, reviewed and resolved.

* Let Intercept Health staff know about the problem.  You can tell staff directly or obtain the name of their supervisor from any staff member in the program and they will explain how to contact him/her.  You can share your complaint and they will attempt to resolve it as quickly as possible to your satisfaction.
* If your complaint is not addressed to your satisfaction you can put it in writing. This becomes a grievance and will be treated as such.
* You can submit a grievance at any time by writing it down and putting it in the box at your service location or by forwarding it to a supervisor. If you need help with the form or with writing your grievance you will receive assistance. The boxes at service locations are to be checked daily and your grievance will be forwarded to the Director of your program. Youth in Treatment Foster Care should contact their Family Consultant.
* The Director or his/her designee of your program will contact you within one business day to confirm that your grievance was received.
* If the complaint or grievance is a violation of your Human Rights, the Director or designee will take measures to ensure your safety immediately and will contact you within 24 hours. Programs licensed by the Department of Behavioral Health and Developmental Services will enter the Human Rights complaint into the Computerized Human Rights Information System (CHRIS) and investigate the complaint.
* The Director or designee will then investigate your grievance and attempt to resolve it to your satisfaction within 10 business days. At the completion of the investigation the Director will contact you to review in writing the findings and explain the action plan.
* If you are dissatisfied with the Director’s decision and action plan you may appeal. You should let him/her know that you are dissatisfied and your intent to appeal by documenting it on the form. He/She will assist by giving you the names and contact information to make your appeal.
* Appeals conducted internally by Intercept Health will be completed within 5 business days of the date of the request for appeal by the Director of Assessment and Accreditation and the Senior Director of Organizational Development.
* Appeals regarding Human Rights violations for programs licensed by the Department of Behavioral Health and Developmental Services will be conducted externally by the Local Human Rights and will be handled within timeframes established in the State Human Rights Regulations

I have received, read and understood The Client Grievance Procedure

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Client Signature Date

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Parent/Guardian Signature (if applicable) Date

**HIPAA Notification – Client Consent Form**

As part of your care, it is necessary to create, maintain, and, in certain situations, share information concerning your history and current care services for treatment, payment, and health care operations. Our **Notice of Privacy Practice**s describes how we may use and disclose your protected information. You have the right to review our notice before signing this consent. You will receive a copy of this notice prior to seeing any provider with our agency.

The terms of our notice may change. We will post a copy of the current notice in our agency. At any time you may request a copy of our current notice in effect.

You have the right to request that we restrict how your information is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by those restrictions to which we agree. Protected health information pertaining to you or your care will only be provided to other parties that you provide us a signed release for. The only times we may release information without a written consent would be in cases of emergencies that require medical attention, when consent cannot be provided, in cases of self-harm or reports of harm to others, and cases of child or elder abuse.

By signing this form, you consent to our use and disclosure of information about you for treatment, payment and health care operations and you acknowledge that you may request a paper copy of our **Notice of Privacy Practices** at any time during the course of your treatment. You have the right to revoke this consent, in writing, except where we have already used or disclosed your information in reliance on your prior consent.

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Client Signature Date

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Parent/Guardian (if applicable) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Client’s Name Date

**\*If signed by the Personal Representative, please describe the Personal Representative’s authority to act for the Client by checking below:**

**\_\_\_\_\_ Parent \_\_\_\_\_ Legal Guardian**

**\_\_\_\_\_ Court Appointed Legal Guardian \_\_\_\_\_ General Power of Attorney**

**\_\_\_\_\_ Health Care Power of Attorney \_\_\_\_\_ Surrogate Decision-Maker**

**\_\_\_\_\_ Next of kin or other family member \_\_\_\_\_ Executor of the Estate**

**\_\_\_\_\_ Other (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization for Disclosing and/or Requesting Information**

|  |  |
| --- | --- |
| Client Name: | DOB: |
| Intercept’s True North Health Clinic is hereby authorized to:  **(      )**Disclose/Send to the following Person/Agency:  **(      )** Request/Receive from the following Agency:  For the purpose of service coordination | |

|  |
| --- |
| Address: |

|  |
| --- |
| Phone Number:  Fax: Number: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ( ) Initial Intake | () Progress Notes | () Ind. Service Plan | () Medication List | () Legal Information |
| () Substance Abuse Assessment | () Counseling Notes | ( ) SASSI | ( ) Drug Screen results | ( ) Participation and Attendance |
| ( ) Diagnosis | ( ) Social History | ( ) Psychological Evaluation | () Discharge Summary | () Other |

|  |
| --- |
| This authorization is effective  and will terminate in one year upon the date, event or condition |

As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations or eligibility are not conditional upon giving authorization. The original or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. This authorization is automatically revoked upon termination of service. The person who receives the records to which this authorization pertains may not re disclose them to anyone else without my separate written authorization unless such recipient is not sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or Federal law protect the disclosed confidential information, Federal Regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Client/Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**Authorization for Disclosing and/or Requesting Information**

|  |  |
| --- | --- |
| Client Name: | DOB: |
| Intercept’s True North Health Clinic is hereby authorized to:  **(      )**Disclose/Send to the following Person/Agency:  **(      )** Request/Receive from the following Agency:  For the purpose of service coordination | |

|  |
| --- |
| Address: |

|  |
| --- |
| Phone Number:  Fax: Number: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ( ) Initial Intake | () Progress Notes | () Ind. Service Plan | () Medication List | () Legal Information |
| () Substance Abuse Assessment | () Counseling Notes | ( ) SASSI | ( ) Drug Screen results | ( ) Participation and Attendance |
| ( ) Diagnosis | ( ) Social History | ( ) Psychological Evaluation | () Discharge Summary | () Other |

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| --- |
| This authorization is effective  and will terminate in one year upon the date, event or condition |

As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations or eligibility are not conditional upon giving authorization. The original or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. This authorization is automatically revoked upon termination of service. The person who receives the records to which this authorization pertains may not re disclose them to anyone else without my separate written authorization unless such recipient is not sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or Federal law protect the disclosed confidential information, Federal Regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Client/Parent/Guardian Signature Date

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Witness Signature Date