Consumer Consent Packet

BLACK INK ONLY

Date: _____

Insurance #: _____ MRN: _____

First Name: _____ MI: _____ Last Name: _____

Email Address: _____

DOB: _____ Gender: _____ S.S. # _____

Physical Address: _____

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

Mailing Address: _____

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

Home Phone #: _____ Alternate Phone #: _____

Primary Language: _____ Secondary Language: _____

Marital Status: _____ Race: _____ Ethnicity: _____

Education Level: _____ Employment: _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Legal Guardian: _____ Relationship: _____ Phone#: _____

Living Arrangements: _____ # in Household: _____

# of Arrests in the last 30 days: _____

Form Completed by: _____ Date: _____

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

CLIENT RIGHTS AND RESPONSIBILITES

Basic Rights Provided to Every Consumer

Directions: Please **initial** each right and responsibility with the consumer or legally-responsible person. This form should be completed at admission, upon request, and annually thereafter.

1. _____ Right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation.
2. _____ Right to live as normally as possible while receive care and treatment.
3. _____ Right to receive age-appropriate treatment, access to medical care and habilitation, and the right to an individualized written program plan within 30 days of admission to maximize his/her development.
4. _____ Right to be informed in advance of the potential risks and alleged benefits of the program choices.
5. _____ Right to confidentiality.
6. _____ Right to be free from unnecessary or excessive medication.
7. _____ Right to be free from medication used for punishment, discipline, or staff convenience.
8. _____ Right to consent to or refuse any treatment offered including behavior management policies; except in emergency situations.
9. _____ Right to request notification after occurrence of any or specified interventions.
10. _____ Right to be informed of any emergency procedures.
11. _____ Right to exercise all civil rights (rights to dispose of property, execute instruments, make purchases, enter into contractual relationships, register and vote, bring civil actions, and marry/divorce) unless the consumer has been adjudicated incompetent.
12. _____ Right to certain safeguards and carefully controlled circumstances when protective interventions are used.
13. _____ Right to social integration, self governance and treatment in the least restrictive, most appropriate environment.
14. _____ Right to be free of corporal punishment, and to be free of neglect, harm, abuse, and exploitation.
15. _____ Right to be free of physical restraint or seclusion.
16. _____ Right to be free from threat or fear of unwarranted suspensions or expulsions.
17. _____ Right to be free from unwarranted invasion of privacy.
18. _____ Right to request notification of the use of an intervention procedure by the legally responsible person for a minor or an incompetent adult. A competent adult may designate an individual to receive information.
19. _____ Right to request notification of the restriction of rights.
20. _____ Right to file a grievance or a complaint with Alliance Behavioral Healthcare Office of Consumer Affairs at 1-800-510-9132.
21. _____ Right to contact Disability Rights of North Carolina: 2626 Glenwood Avenue, Suite 550 Raleigh, NC 27608; Phone: 1-877-235-4210.

Consumer Responsibilities

1. _____ The consumer will make him or herself available for meetings in the home, community, or at the agency.
2. _____ The consumer will meet with physicians or other providers as scheduled. 24-hour notice required for rescheduling or canceling appointments. Failure to provide notice will result in a $35 fee. Two cancellations or missed appointments may result in termination of services.
3. _____ The consumer will participate in the treatment planning process and sign as required.
4. _____ The consumer will call the agency if moving (change of address), hospitalized (for any reason), or leaving the local area for an extended period of time.
5. _____ The consumer will inform the agency of any changes in funding or insurance coverage.

Consumer Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Carter Clinic Staff Signature: _____ Date: _____

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

Notice of Privacy Practices

Important Information About How Your Information May Used and Disclosed, As Well As How You Can Access Your Information and Release Information to Other Agencies

The Carter Clinic has a clear policy to protect your confidentiality. We are required by law to protect all confidential consumer information and *Protected Health Information* (PHI), and adhere to all guidelines to protect consumer information as listed in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. You have a right to confidentiality and you may report any violations of confidentiality to Disability Rights of North Carolina at (1-877-235-4210) or Office for Civil Rights, US Department of Health and Human Services at (1-404-562-7886).

Written Consent Required To Release Information: Only records or information, with appropriate written consent by the consumer, may be released with identified parties. The release must specify who may send or release information, as well what specific information may be released. The written release is valid for one year, but may be revoked at any time. If you sign a release of information, you are entitled to receive a copy of the signed release. Also, we may only release information that was generated by The Carter Clinic. For example, if you provided a release for us to receive specific records from another agency, we are not permitted to release those records to other parties. You will need to contact that agency if you need those records released.

The Local Management Entity/Managed Care Organization (LME/MCO) is responsible for oversight of mental health services. Basic information such as progress on goals, demographic information, and diagnostic information may be given to the Local Management Entity/Managed Care Organization for review and authorization of services.

Access to Medical Records: Consumers, guardians, or legal representatives have a right to have access to medical records. While the actual record is property of The Carter Clinic, you may request to review all or part of the record. You if choose to review the records, you must sign a written release and you may set an appointment with a supervisor to review your records. Only records generated by The Carter Clinic may be released. If you request copies of all or part of the record, a small fee may be charged (not to exceed $35.00 for administrative costs).

Retention and Destruction of Records: The Carter Clinic retains all medical records for five (5) years in a secure location. If records have been involved in legal proceedings, records are maintained for seven (7) years.

Limits of Confidentiality: The Carter Clinic is required to report incidents or suspected incidents of abuse of a child, disabled person, or elder person to local officials. If a consumer reports a plan to harm another individual, local law enforcement and that potential victim may be contacted to ensure safety. Additionally, if there is a psychiatric or medical emergency, The Carter Clinic may release information to emergency personnel to assist in coordination of emergency services.

If you have any questions regarding confidentiality, our policies to protect your information, or processes to file a grievance, please feel free to contact The Carter Clinic at (919) 848-0132.

Consumer Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Carter Clinic Staff Signature: _____ Date: _____

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

Acknowledgement of Consumer Choice

☐ I choose to receive:

- ☐ Clinical Outpatient Therapy Services
- ☐ Psychiatric Services
- ☐ Peer Support Services
- ☐ Individual Support Services
- ☐ SAIOP
- ☐ SACOT

☐ I choose to decline _____ (service) from The Carter Clinic, P.A.

Consumer Signature: _____ **Date:** _____

Legal Guardian Signature: _____ **Date:** _____

Carter Clinic Staff Signature _____ **Date:** _____

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

Consent for Treatment

Directions: Please **initial** each line and check appropriate box giving consent to receive treatment/services.

_____ **Program Consent:** After clear explanation of program structure, rules, and expectations, I give consent for ( ) me ( ) child ( ) other to receive ( ) **Outpatient Therapy Services** ( ) **Psychiatric Services** ( ) **Peer Support Services** ( ) **SAIOP/SACOT** from THE CARTER CLINIC. I understand that this is voluntary and that this consent may be withdrawn with written notification at any time.

_____ **Interventions:** I agree to allow THE CARTER CLINIC staff to implement professionally accepted methods of intervention as indicated by the consumer's and program's mutually agreed upon therapeutic treatment/goal plans. It is the policy of THE CARTER CLINIC that physical restraint of consumers and isolation time-out will be avoided. In an emergency where the staff member has exhausted verbal de-escalation techniques and a consumer is still being physically aggressive, a threat to self or others, or is destroying property, the staff member will call 911 and request intervention by law enforcement. The potential benefits of interventions, though not guaranteed, are alleviation of mental health and/or substance abuse treatment symptoms necessitating the need for treatment. The risks of the service are discussing and addressing challenging symptoms associated with diagnoses and the potential emotional discomfort that this may cause. THE CARTER CLINIC does not condone the use of experimental interventions or medications. You have a right to be informed about the potential risks and benefits of all services and interventions provided by THE CARTER CLINIC.

_____ **Role of the Local Management Entity/Managed Care Organization:** The Local Management Entity/Managed Care Organization is responsible for oversight of mental health/ substance abuse services, and authorization services for consumers who have Medicaid, Health Choice insurance, or IPRS. Basic information such as progress on goals, demographic information, and diagnostic information may be given to Local Management Entity/Managed Care Organization for review and authorization of services.

_____ **First Aid/Medication Administration:** I authorize THE CARTER CLINIC to provide and render first aid assistance to the consumer as deemed necessary by trained and certified staff. I understand that, during the time THE CARTER CLINIC staff is with the identified consumer.

_____ **Emergency Care:** I authorize THE CARTER CLINIC to obtain emergency medical, dental or mental health care for this consumer, if needed, until such times that I can be reached to authorize further care.

_____ **Acceptance:** I (we) have read and/or have been clearly explained the terms, conditions and agreements of this informed consent agreement and voluntarily accept them as stated or amended as specified below. This agreement may be withdrawn at any time, but will not exceed one year after the date signed.

Expiration Date of Informed Consent for Service Delivery: _____
(Not to exceed one year)

Consumer: _____ **Date:** _____

Legal Guardian: _____ **Date:** _____

Carter Clinic Staff Signature: _____ **Date:** _____

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

Emergency Medical Treatment Consent

I, _____ (consumer, guardian) give permission for The Carter Clinic providers to transport and provide emergency medical care for the consumer.

I understand The Carter Clinic provider will try to reach the legal guardian and/or individuals listed on the Emergency Contact List as quickly as possible in an emergency situation. I agree to hold The Carter Clinic harmless from any liability that results from the provision of transportation or medical coordination.

Emergency Contact Name(s):		Phone:	
		Phone:	
Consumer Physician's Name:		Phone:	
Insurance Information:			
Hospital Preference:		Phone:	
Medical Conditions:	☐None Reported ☐ Yes; Explain:		
Allergies :	☐None Reported ☐ Yes; Explain:		
Medications:	☐None Reported ☐ Yes; Explain:		

If the above physician cannot be reached, a licensed physician can be called or the above-named consumer may be taken to the nearest hospital emergency room if necessary. I understand that this consent is valid for one year and may be revoked, in writing, at any time.

_____ _____

Consumer/Legal Guardian Signature / Date Carter Clinic Staff Signature / Date

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

Screening Instrument for Infectious Tuberculosis

1. ☐ Yes ☐ No Have you seen a doctor or health care provider in the past three (3) months?
2. ☐ Yes ☐ No Have you or do you now live in a shelter or on the street?
3. ☐ Yes ☐ No Have you been in jail or prison in the past year? For how long? _____
4. ☐ Yes ☐ No Have you had a TB skin test in the past year? What were the test results? _____
5. ☐ Yes ☐ No Have you ever been told you have TB?
6. ☐ Yes ☐ No Have you been treated for TB?
7. ☐ Yes ☐ No Has anyone you known or lived with been told they have TB in the past year?
8. Within the past thirty (30) days have you had any of the following symptoms for two (2) or more weeks:
   - ☐ Yes ☐ No Fever
   - ☐ Yes ☐ No Drenching night sweats that made it necessary to change clothing or sheets
   - ☐ Yes ☐ No Productive cough
   - ☐ Yes ☐ No Coughing up blood
   - ☐ Yes ☐ No Shortness of breath
   - ☐ Yes ☐ No Lumps or swollen glands in the neck or arm pits
   - ☐ Yes ☐ No Unexplained weight loss
   - ☐ Yes ☐ No Diarrhea lasting a week or more
9. Have you or do you live with anyone who has who has either of these symptoms:
   - ☐ Yes ☐ No Coughing up blood
   - ☐ Yes ☐ No Drenching night sweats

Other Relevant Information:

_____

_____

_____

☐ CONSUMER DOES NOT APPEAR TO BE AT RISK

☐ CONSUMER APPEARS TO BE AT RISK AND HAS BEEN REFERRED TO _____ FOR FOLLOW UP

Carter Clinic Staff Signature: _____ Date: _____

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

Consumer Orientation Checklist

Directions: Please initial each area that was reviewed with you during the orientation process. A written summary is provided for you in the Orientation to Services packet.

1.		Consumer Rights and Responsibilities.
2.		Notification of consumer choice and referral process.
3.		Notice of Privacy Practices to include limits of confidentiality.
4.		Process to file a written grievance with The Carter Clinic to include receipt of the grievance form.
5.		Process for contacting the State or local LME/MCO with concerns or grievances.
6.		Consumer feedback, suggestion boxes, and requests for the removal of barriers process.
7.		Detailed program summary (Consent for treatment).
8.		Policy (review) on suspensions and expulsions for services.
9.		Policy (review) regarding least restrictive interventions.
10.		Admission, Transition, and Discharge Criteria.
11.		Expectations for participation in Treatment Plan, Treatment Team Meetings (as applicable), and Transition Planning.
12.		The Carter Clinic prohibition of restraints and "hands-off" policy.
13.		Review of tobacco policy and prohibition of drugs/alcohol on premises.
14.		No weapons policy (review).
15.		Basic information regarding The Carter Clinic to include its Code of Ethics.
16.		Office hours and holiday schedule, as well as parking accessibility.
17.		On-call services and contact numbers.

Consumer Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Carter Clinic Staff Signature: _____ Date: _____

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

Acknowledgement of Emergency Crisis Information

I acknowledge I have received a copy of the Carter Clinic, P.A.'s emergency crisis phone number/information line, (919) 848-0132. I understand that it is available **24/7/365** for behavioral health crises. If I call that number after hours, I will be connected to the answering services who will connect me to a mental health professional in the case of an emergency.

_____ _____

Consumer/Legal Guardian Signature Date

_____ _____

Carter Clinic Staff Signature Date

NAME: _____ MRN #: _____ DOB: _____

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

☐ **I hereby declare that I do not have a primary care physician or other health care providers or the designees as deemed necessary to perform reasonable and necessary medical examinations, testing and/or treatment for the condition which has brought me to seek care at this facility.**

☐ **I hereby authorize:** _____

(Facility Name)

_____

(Facility address, telephone, and fax number)

to share the specified information in my client record with The Carter Clinic, 919-848-0277 (fax).

This data shall include (Client/Legal Guardian should check each item to be released):

Psychological Evaluation	☒	HIV		School Attendance Record	
Psychiatric Evaluation	☒	Alcohol/Drug Treatment		School Conduct Record	
Screening/Client Profile		Hepatitis		Educational Information	
Lab Results (If Applicable)	☒	Medication Information	☒	Summary of Eval/Treatment	☒
Diagnosis	☒	Financial Reimbursement		Intake Information	
Service Plan		Progress Notes	☒	Discharge Summary	
Other/Disclosures made regarding:					

The purpose of the disclosure is for/to: ☒ Assist with treatment ☐ Referral ☐ At request of client

☐ Other (please explain): _____

I hereby acknowledge that The Carter Clinic has not conditioned my treatment on signing this authorization, and that I may refuse to sign this authorization if I so desire. I also recognize that I retain the right to revoke this authorization in writing at any time, except to the extent that the agency has already taken action in reliance on the consent. Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (GS 122-C), substance abuse treatment information protected by federal law (42 CFR Part II) or HIV/AIDS information protected under GS 130A-143, this organization informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these laws.

If not revoked earlier, this authorization expires automatically on _____ or one year from the date it is signed, whichever is earlier.

I HAVE READ THIS INFORMATION AND UNDERSTAND THAT THERE ARE STATUTES AND REGULATIONS PROTECTING THE CONFIDENTIALITY OF AUTHORIZED INFORMATION. I HEREBY 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.

_____ and/or _____

Consumer Signature — Legally Responsible Person

_____ _____

Date — Relationship to Client

_____

Carter Clinic Staff Signature

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

Refusal of Coordination of Care

At this time, I decline any Coordination of Care either because I am not receiving services with a Primary Care Provider or any Health Care Facility, or I refuse to allow communication with other providers.

I understand I have this right without threat or termination of services.

_____ _____

Consumer/Legal Guardian Signature Date

_____ _____

Carter Clinic Staff Signature Date

Consumer Name: _____ Medical Record #: _____

Date of Birth: _____ Insurance #: _____

Legal Guardian, *if applicable*: _____

Telepsychiatry Informed Consent

Introduction

Telepsychiatry is the form of telemedicine that allows patients to access psychiatric care using audio-video interface such as videoconferencing.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional and unintentional corruption.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of telepsychiatry which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry in the course of my care at any time, without affecting my right to future care or treatment. However, I understand I may have to travel further to obtain care.
3. I understand that a variety of alternative methods of psychiatric care may be available to me, and that I may choose one or more of these at any time.
4. I understand that it is my duty to inform my psychiatrist of any other healthcare providers involved in my medical/psychiatric care.

Patient Consent to the Use of Telepsychiatry

I have read and understand the information provided about regarding telepsychiatry, have discussed it with my psychiatrist or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care.

I hereby authorize Carter Clinic, P.A. to use telepsychiatry in the course of my diagnosis and treatment.

_____ _____

Consumer/Legal Guardian Signature Date

_____ _____

Staff Signature Date