WOL Word of Life
Behavioral Health Services

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Consumer Emergency Medical Information

Last Name	First Name	Initial	Register Number

Physician's Name	Telephone Number	Beeper/Emergency Number

Name of person to notify in case of emergency	Relationship

Address	Home Phone Number	Work Phone Number

Hospital of Preference	Telephone Number

Address

Pharmacy of Use	Telephone Number

Allergies:

Medical Conditions:

Psychiatric Conditions:

Therapist	*Date*

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Child, Adolescent and Family Counseling
1011 East Avenue
North Augusta, SC 29841

Phone: 803-474-5129 Fax: 803-474-5138

Today's Date: _____

Dear Consumer:

Welcome to our office! Thank you for entrusting us with your mental and emotional well being. It is important that you understand our office policies. We are a small mental health practice specializing in the personal touch. In any appropriate way, we will serve you and help you meet your needs.

APPOINTMENTS

_____ has been referred to our office by_____
Please note: We will schedule you for Therapy once all paperwork has been completed for intake and the initial assessment has taken place, unless other arrangements have been made.

You will find in this packet of forms regarding patients, parents/guardians, your child and possibly affiliates of the respective school system. Please fill in all blanks and indicate 'none' or N/A for questions that do not apply.

Your appointment time is reserved exclusively for you. We do not double book appointments in this office. We ask that you consider the importance of making scheduled appointments as your primary goal for treatment. Please know that our commitment is to provide service excellence and not keeping appointments may slow that process. If you miss three (3) consecutive appointments, without notice or contact with your therapist, may result in your case being closed.

Please initial confirming that you have read the above statement: _____

Sincerely,
Word of Life Behavioral Health, LLC

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Phone: 803-474-5129 1011 East Avenue Fax: 803-474-5138
North Augusta, SC 29841

RELEASE OF INFORMATION

Name:_____ Date of Birth:_____
Social Security Number:_____

I hereby authorize Word of Life Behavioral Health to:
_____Release records to:
_____Receive records from
_____Share information
(to include written and verbal communication)

Print name and address of person/agency:
_____
_____
_____
(one agency/person per release)

Please include the following:

_____Psychological Eval	_____Lab Results	_____Hospital Records
_____Psychiatric Eval	_____Service Plan	_____Continuity of Care
_____Clinical Notes	_____Correspondence	_____Re-disclosure
_____Intake /Assessment	_____School Records	_____Other
_____Discharge Summary	_____School Testing	
_____Drug and Alcohol Treatment	(including Psycho-ed, Speech, Hearing IEP, SNAPS)	

This consent shall be valid for:_____(not to exceed one year).

I acknowledge Word of Life Behavioral Health has not conditioned my treatment on signing this authorization and that I may refuse to sign this authorization if I choose to. I understand that Word of Life Behavioral Health cannot deny or refuse to provide treatment, payment or eligibility for benefits on my refusal to sign.
Once information is disclosed in regards to this signed authorization, I understand that the HIPAA privacy law protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from re-disclosing it. When Word of Life Behavioral Health's office does disclose mental health and developmental disabilities information protected by state law or substance abuse treatment information prohibited except as permitted of required by law.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reference to it. If I revoke the authorization, I must do so in writing by submitting a signed revocation statement to Word of Life Behavioral Health at 1011 East Avenue, North Augusta, SC 29841.

Client Signature _____Date_____

Signature_____Date_____
_____Parent _____Guardian _____Legally Responsible Person
(required for all clients under 18, guardian must show proof of guardianship)

TO BE COMPLETED IF CLIENT IS PHYSICALLY UNABLE TO SIGN
I, the undersigned, do verify that the above named patient is physically unable to sign this consent form and that he/she wishes to released records described above, understands the nature and purpose of the release, and freely gives his/her consent for the release of information.
Witness:_____Date:_____

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North Augusta, SC 29841

Name:_____DOB:_____Sex:_____

Address:_____SSN:_____

City, State, Zip:_____Race:_____

Phone Numbers: 1. _(___)_____2._(___)_____3._(___)_____

Marital Status: S M D W OTHER Employed: Y or N Student: Y or N

Employer/School Name:_____Phone:_____

Address:_____

Financially Responsible Person: (If different from client)_____

SS#_____Sex (M or F) # _____Relationship to client#_____

Address:_____Phone:_____

Emergency Contact (___)_____Relationship to client#_____

INSURANCE INFORMATION

PRIMARY:_____ Policy/Group #:_____ Phone: ( )_____

Address: _____ Employer: _____

Relationship to Patient: _____ DOB: _____ SS#: _____

SECONDARY: _____ Policy/Group #: _____ Phone: ( )_____

Address: _____ Employer: _____

Relationship to Patient: _____ DOB: _____ SS#: _____

Primary Care Provider: _____ Phone: ( )_____

Address: _____ Phone: ( )_____

May our office contact you PCP? Y or N

I hereby authorize release of any medical information necessary to process insurance claims. I authorize payment of medical benefits directly to this practice for the services rendered. I understand I will be responsible for the difference between charges allowed and insurance payment (i.e. Medicare allowances, managed care fee schedules, deductibles)

SIGNATURE: _____ DATE: _____

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Do you consent to have anyone to participate in your/your child's treatment?

Who? _____

_____

_____

FEES AND FINANCIAL POLICY

1. An initial office visit (one hour) is $210 for adults and children. Subsequent office visits are based on length of visit and complexity of issues but may range from $80-$160. If you have private insurance please come prepared to pay for your first visit and we will reimburse you as soon as we receive payment from your insurance company.

2. Because insurance plans differ widely as to what they provide for mental health, please check with your insurance company ahead of time to see what part of the fee they will cover.

3. If you have a co-pay, we will ask for it at the time of your appointment. Otherwise, we will expect payment in full if you have made no other arrangements with us in advance. Deductibles are your responsibility. At the first of the year, or until deductibles are met, we ask that you pay up front and in full unless other arrangements have been made ahead of time.

4. From time to time WOL is able to make arrangements with your insurance company even though he is out of network. Please remember that whatever your insurance does not cover remains your responsibility.

5. We accept cash, personal checks, money orders, Visa and MasterCard.

6. We will file your insurance as a courtesy for you and bill you for any unpaid balances. If after a reasonable amount of time your bill remains unpaid, we will seek other means of collecting the monies from you. If you are paid directly by your insurance company; we will request payment in full each visit. You may contact our office if you have a question about your bill or need to make arrangements for monthly payments.

7. ALL your insurance coverage cards, both primary and secondary, must be presented at the time you return your packet, so we can work on any insurance issues prior to your first visit. Please inform us of any insurance changes.

8. We need accurate information from you. We need your full legal name, a working telephone or cell phone number and accurate address at all times. Please notify us any time you change your name, phone number, address or insurance company.

Fees and Financial Policy Section _____ (please initial)

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Consumer Orientation

Please indicate that you have received and read the client/consumer orientation book

Signature:_____ Date:_____

POLICIES FOR SPECIAL CIRCUMSTANCES

1. WOL provides Diagnostic Assessment and counseling. WOL does not meditate in legal or divorce situations nor complete custody evaluations. If for any reason you require an attorney or if referred here by an attorney; the expenses for legal testimony or documents will be billed directly to him/her.

2. WOL does not perform formal psychological testing nor does WOL complete disability evaluations. We will send copies of your clinical notes, if requested, to a referring physician, agency, or Social Services. We will bill for any time taken to complete letters or forms for your insurance company attorney or any other third party, once we have permission.

3. Should interpretive services be needed, notify our office when returning your new patient documents.

I have read and understand the policies stated above and agree to abide by them.
Signature: _____ Date:_____

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HIPAA DISCLOSURES AND RULES FOR OUR PATIENTS

The covered entity in this statement refers to our office only, this is a personalized statement and should not be confused with any other HIPAA statements you have read in other behavioral health offices.

The HIPAA privacy rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information concerning their public health mission. The rule also recognizes that public health reports made by covered entitles are important means of identifying threats to the health and safety of the public at large, and as individuals. Accordingly, the rule permits covered entitles to disclose protected health information without authorization for specified public health purposes.

Privacy and confidentiality as it pertains to our patients: Privacy is about whom has the right to access personally identifiable health information. This covers all individually identifiable health information in the hands of covered entitles, regardless of where the information is or has been in electronic form.

Privacy Standards are as follows:

1. Limit the non-consensual use and release of private health Information.
2. Give new patient rights to access their medical records and lo know who else has accessed them.
3. Restrict most disclosure of health Information to the minimum needed for the Intended purpose.
4. Establish new criminal and civil sanctions for improper use or disclosure.
5. Establish new requirements for access records by researchers end others.

The five basic principles of privacy are:

1. Consumer Control: the regulation provides consumers with critical new rights to control the release of their medical information.
2. Boundaries: with few exceptions, an individual's health care information should be used for medical purposes only, including treatment and payment.
3. Accountability: under HIPAA, for the first time, there will be specific federal penalties ◆ a client's right to privacy Is violated.
4. Public Responsibility: the new standards reflect the need to balance privacy protections with public responsibility to support such national priorities as protecting public health, conducting medical research, improving the quality of care, and fighting health care fraud and abuse.
5. Security: It is the responsibility of organizations that are entrusted with health information to protect it against deliberate or inadvertent misuse or disclosure.

The Privacy Rule permits our office to disclose protected information, without authorization, to public health authorities who are legally authorized to receive special reports for the purpose of preventing or controlling disease, injury or disability. This would include, for example, the reporting of a disease or Injury; reporting vital events, such as births or defects; and conducting public health surveillance, investigations or interventions. *Any* covered entity may, et the direction of e public health authority, disclose protected health information to a foreign government agency that Is agency in collaboration with a public health authority. Covered entities who are also a public health authority may use, is well as disclose, protected health information for these public health purposes.

A "public health authority" is an agency or authority of the United States government, a Slate, a territory in a political subdivision of a State or territory, or Indian tribe that Is responsible for public health mailers of its official mandate, is well as a person or entity acting under e grant of authority from, or under a contract with, a public health agency. Examples of a public health authority In Slate and local health departments are: The Food and Drug Administration, The Centers For Disease Control and Prevention and The Occupational Safety and Health Administration.

As a general rule our office is required, reasonably, to limit the protected health information disclosed for public health purposes lo the minimum amount necessary to accomplish the public health purpose. We are not required to make a minimum necessary determination for public Information disclosures that are made pursuant to an individual's authorization, or for disclosures that are requiring other law. For routine and recurring public disclosures, such as a release of information to a doctor, school, institution or other professional. We will develop standard protocols, as o part of our minimum necessary policies and procedures, that address the types and amount of protected health information that may be disclosed for such purposes.

Other Public Health Activities: The Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities. This allows covered entities, such as our medical office, to disclose protected health information, without authorization, to such personal entities for the public health activities discussed below:

1. Child abuse or neglect: our office may disclose protected health Information to report known or suspected child abuse or neglect, If the report is made to a public health authority or appropriate government authority that is authorized by law to receive such reports. For Instance: social services department of a local government might have the legal right to receive reports of child abuse or neglect in which case, the Privacy Rule would permit a medical office or any covered entity lo report cases to that authority without obtaining individual authorization. Likewise, a covered entity can report such cases to the police department when the police department Is authorized by law to receive such reports.

2. Persons at risk of contracting or spreading a disease: a covered entity may disclose provider health information to a person who is at risk of contracting or spreading a disease or condition. No other law authoriz the covered entity to notify such individuals as necessary to carry out public health interventions or investigations.

3. Workplace medical surveillance: a covered health care provider who provides health care service to an individual at the request of the individual's employer, or provides the service in a capacity of a member of the employer's workforce, may disclose the individual's protected health information to the employer for the purpose of workplace medical surveillance or the evaluation of workplace illness and injuries to the extent the employer needs that information to comply with OSHA, the Mine Safely and Health Administration, or the requirements of state laws having similar purpose. The information disclosed must be limited to the provider's findings regarding such medical surveillance or work-related illness or Injury. The covered health care provider must provide the Individual with written notice that the information on will be disclosed to his or her employer or the notice must be posted at the worksite if that is where the service is provided.

HIPAA as it applies lo our individual practice: Psychiatry. One of the most important sections for our office has to deal with children and adolescents end the psychotherapy notes. The American Academy of Child & Adolescent Psychiatry (AACAP) had originally asked that HIPAA laws respect the right to privacy for minors· over their medical records. In many slates, as In South Carolina, a parent Is allowed to have access to the medical records about his or her child, is their personal representative. There are three situations when the parent would not be the minor's personal representative under the Privacy Rule, they are:

1. When the minor is the one who consents to care and the consent of the parent is not required under State or other applicable law.

2. When the minor obtains care at the direction of a court or person appointed by the court.

3. When, end to the extent that, the parent agrees that the minor and the health care provider may have a confidential relationship.

Even with these exceptional situations, the parent may have access to the medical records of the minor related to this treatment when State or other applicable law requires or permits such parental access. Parental access would be denied when State or other law prohibit their access. If a State or other law is silent on a parent's right of access in cases, the licensed health care provider may exercise his or her professional judgment to the extent allowed by law to grant or deny parental access to the minor's medical information

As is the case with respect to all personal representatives under the Privacy Rule, Word of Life Behavioral Health, LLc reserve the right to withhold a parent's access to a child's records if they reasonably believe, in their professional judgment, that the child has been or may be subjected to domestic violence, abuse or neglect, or that treating the parent as the child's personal representative could endanger the child.

As a final note, we will take all measures to insure privacy and security while you are a client with our office. Some of the measures we take include: turning our computer screens, turning charts over so as not to see the name, keeping our scheduling book in an area where only we can read it and not saying a patient's full name aloud for everyone to hear it. We do this for your privacy and securities as well as every other patient in our office so please do not ask us to compromise our rules just to make things easier for you/anyone. By this we are asking that you not look at our scheduling book or our computer screens, and please, do not go through other patient's charts that are sitting on the front desk.

Please sign and date after you have read this statement. If *you* have any questions at all please ask us and we will be happy to help you

_____ _____

Patient Signature **Date**

_____ _____

Signature of Guardian/Legal Representative **Date**

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FAMILY INCLUSION PLAN/PERSON TO CONTACT

I, _____, address _____

date of birth _____, Last four of SSN# _____, medical record #_____ authorize WOL Behavioral health information, to contact the following name person(s), to invite to be a part of my treatment/Recovery.

Name:_____ Name:_____

Address:_____ Address:_____

_____ _____

Telephone No._____ Telephone No._____

Relation to consumer_____ Relation to consumer._____

Name:_____ Name:_____

Address:_____ Address:_____

_____ _____

Telephone No._____ Telephone No._____

Relation to consumer_____ Relation to consumer._____

This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here I understand that information disclosed may be subject to re-disclosure by the entity named above. I may cancel this Authorization by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization, WOL cannot take back any use or release made with my Authorization, and WOL must keep records of my treatment. I understand that I may refuse to sign this Authorization and my refusal will not limit my access to WOL treatment or other services. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my Authorization. I have been given a copy of this Authorization.

_____

Signature of Individual/Personal Representative Printed Name Date

Authority if signed by Personal Representative_____

_____

Signature of WOL Staff releasing information Printed Name Method of Release Date Released

FAMILY INCLUSION PLAN