Second Chance Behavioral Health

INITIAL SCREENING/INTAKE FORM

Date of Intake

CLIENT NAME:_____ MRN:_____

GENDER:_____ RACE:_____

REFERRAL SOURCE:_____

DOB:_____ SSN:_____

ADDRESS:_____

COUNTY:_____ ZIP:_____

PHONE #:_____ EMAIL:_____

PREFERRED REMINDER METHOD (text, email, phone):_____

INSURANCE INFO:

Aetna, Cigna, BCBS, Medicaid, NC Health Choice, UHC, Self-Pay

Primary Ins #:_____

Secondary Ins #:_____

LEGAL GUARDIAN INFO:

NAME:_____ Relationship_____

ADDRESS:_____

PHONE:_____

PRESENTING PROBLEMS:

_____

_____

Second Chance Behavioral Health

Authorization to Release Information

Client Name_____ Date of Birth_____

Record Number_____ Medicaid ID Number_____

I hereby authorize the release of specified treatment information from the agency/person listed below to Second Chance Behavioral Health and from Second Chance Behavioral Health, to agency/person listed below for the purpose of continuity of care, mental health treatment and coordination of necessary services.

Agency/Person:

Please **check** below indicating which documentation regarding your treatment may be released/exchanged.

_____Reason for Referral/Screening
_____Assessments
_____Psychological /Diagnosis
_____History of Psychotropic Medication Use
_____Academic Achievement and Behavior
_____Social/Developmental History
_____Medical Information
_____Service Plan/Service Notes
_____Authorization to release information pertaining to HIV/AIDS
_____Authorization to release information pertaining to substance abuse
Other_____

I understand that the federal Privacy Law (45 CFT Part 164) protecting Health information may not apply to the recipient and, therefore may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. Second Chance Behavioral Health does not release information generated from other agencies.

I understand the contents to be released, the need for the information and that the information to be release is protected under State and Federal Law and cannot be re-disclosed without my further written consent as authorized by G.S. 122C-53 through G.S. 122C-56. Second Chance Behavioral Health Notice of Privacy Practices described the circumstances where disclosure is permitted or required by state or federal laws.

I understand that I may revoke this consent at any time and there can be no legal ramifications placed on SCBH for information that was released prior to the revocation. I understand that this consent will expire in one year from the date of my signature. I understand that I have the right to indicate the preferred date to revoke this consent in the comment space provided at the bottom of this form.

_____ _____ _____

Consumer/Legal Representative Date Authority of Legal Representative

_____ _____

Staff Signature Date

Comments or exceptions to this consent:

_____

_____

_____

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Staff Signature Date

Comments or exceptions to this consent:

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SECOND CHANCE BEHAVIORAL HEALTH
2719 Neuse Blvd., Suite D
New Bern, NC 28562

NORTH CAROLINA DIVISION OF MENTAL HEALTH
DEVELOPMENTAL DISABILITIES AND
SUBSTANCE ABUSE SERVICES

CLIENT NAME:_____ RECORD NUMBER:_____

CONSENT FOR TREATMENT/PSYCHIATRIC SERVICES AGREEMENT

CONSENT FOR TREATMENT

_____ I hereby request admission to Second Chance Behavioral Health, PA for evaluation and/or treatment. If the evaluation indicates that admission is appropriate. I consent to such services as may be prescribed by the clinician(s) responsible for my care. If the evaluation indicates that I would not benefit from services available at the agency or that needed services are not offered by the agency I will be referred to a more appropriate resource for assistance.

_____I understand that if I need to cancel or re-schedule my appointment I should provide at least a 24 hour notice on the day prior to my schedule appointment to avoid being charged a no show fee of $35.00.

_____I also understand if I miss two (2) consecutive scheduled appointments without providing a 24 hour notice of cancellation I may be discharged from SCBH at the discretion of my Clinician(s).

CONSENT FOR EMERGENCY MEDICAL SERVICE

_____ I hereby grant permission to SCBH and Trillium Health Resources to seek emergency medical services on my behalf if that should become necessary. A hospital, physician and/or emergency contact design immediately. The agency is not responsible for any change that are incurred as result of emergency medical services.

MESSAGE OPTIONS

_____I hereby grant permission to SCBH to leave a message on my home phone, cell phone and/or to contact me via e-mail or through text message according to my preferences. ***Please circle all preferences***

RELEASE OF INFORMATION TO THIRD PARTY PAYORS

_____Trillium health Resources and SCBH is authorized to release information from my client service record to my insurance company, BCBS, Medicare, UHC, Cigna or other in order to process sand pay claims for services rendered to me.

_____ I understand that this consent allows the release of all information in my client service record including substance abuse, communicable diseases (including AIDS/HIV), and other sensitive documentation as specified in the need.

ASSIGNMENT OFBENEFITS

_____I hereby authorize payment directly to SCBH of any insurance or government program benefits otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not paid under this assignment. If my visit today is with a clinician that is Non-Covered by insurance company, I understand that I will be responsible for those charges. Any refunds due me shall be applied to any other outstanding balance for which I am responsible at Second Chance Behavioral Health, PA.

RECEIPT OF HUMAN RIGHTS INFORMATION

_____I acknowledge receipt of the listed documents and have been given a complete and satisfactory explanation of their contents and purpose:

Your Right as a Client at Our Family (SCBH Client Rights)
Notice of Privacy Practices/Service Related Grievances &Complaints HIPPA Regulations)

I understand all of the statements above. The consents shall be valid for one (1) year or until the cessation of services and/or the revocation of said consents. I also understand that my Protected Health Information will not be released without my written consent.

_____ _____
Signature of Client/Legally Responsible Person Signature of SCBH Staff

_____ _____
Date Date

Acknowledgement of Receipt
Trillium Health Resources
And
Second Chance Behavioral Health
Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" for Coastal Care and Second Chance Behavioral Health.

I have carefully reviewed the Notice of Privacy and have had an opportunity to discuss it with the Agency personnel that provided it to me.

I understand that I may contact the appropriate Agency Privacy official or their designee, as indicated at the end of the Notice of Privacy Practices, if I have questions about the content of the notice or have a privacy-related complaint.

Print Client Name (Last, First, MI)_____

Print Previous Name/Maiden Name (if applicable)_____

Date of Birth_____ Social Security Number_____

_____ _____

Signature of client or personal Representative Date

_____

Authority of Personal Representative

_____

Signature of Witness (Agency Representative)

For Agency Use Only: If individual/personal representatives refuses to sign acknowledgement, please indicate step taken to obtain acknowledgement and individual/personal representative's reason for refusal to provide acknowledgement:

_____

_____

CLIENT RESPONSIBILITES

- You have the responsibility to provide as much information as possible about your health, medical history, and insurance benefits.

- It is your responsibility to pay your bill in full at each appointment. If you are having financial difficulty, it is your responsibility to notify the business offices so that arrangement can be considered.

- Its your responsibility to disclose any other care you are receiving and medications that you are taking. Typically, client receiving Enhanced mental health Services (such as Intensive in Home or Day Treatment Services) are not eligible for outpatient therapy at the same time. Please bring all current medication bottles to your initial visit with our clinician(s) and update us about any medication change made while you are receiving services here.

- You have the responsibility of keeping appointments and adhering to your agreed-upon treatment plan. Please call us as soon as you are aware of a change that must be made to an upcoming appointment. SECOND CHANCE BEHAVIORAL HEALTH RESERVES THE RIGHT TO CHANGE AN ADMINISTRATIVE FEE, WHEN LAWFUL TO DO SO, FOR APPOINTMENTS THAT ARE CANCELED OR RESCHEDULED WITH LESS THAN 24 HOURS NOTICE.

- Its is your responsibility to tell us if your name, address, telephone number, or emergency contact changes.

- Insurance Card(s) should be brought to every appointment. Please let us know if there have been any changes. If there have been changes, but the active insurance cannot be verified due to an inability to bring said card(s) to the appointment, we reserve the right to collect full payment from you until proof of insurance is provided.

- You are responsible for making the insurance copayment at the time of visit unless other arrangement has been previously made. If you occur charges for an appointment canceled of reschedule with less than 24 hours' notice, you will be fully responsible for payment as insurance does not cover this type of fee.

- It is your responsible to notify our staff of medication refills you may require 5-7 days prior to running out of said medication.

- Our staff is happy to write any official letters that you may require, but ask that you allow us 14 days' notice and pay a fee of $30 upon letter request.

- Its your responsibility to treat staff and others here with respect and consideration. You are also responsible for respecting other clients' rights and confidentially. Failure to do so may result in discharge.

- Weapons, illegal drugs, and alcohol beverages are not permitted on the vicinity. It is your responsibility to assure that those accompanying you to your appointment also adhere to this policy.

- You are responsible for providing supervision for your child while at Second Chance Behavioral Health. If you are here for your child's initial assessment, and your child is under the age of 6 or if you bring any other children under the age of 6, another adult must accompany you to supervise the child/children in the waiting area while you are being interviewed.

My signature confirms that I understand my rights and responsibilities as a client of Second Chance Behavioral Health.

Client Printed Name: _____

Client Signature:_____ Date:_____

Guardian Signature:_____ Date:_____
(For clients under 18)

Staff Signature:_____ Date:_____