IMPACT
BEHAVIORAL HEALTH
AND RECOVERY CARE

1616 W Shaw Ave Ste B2, Fresno Ca 93711 (559)293-3174, Fax 559-570-0194

NEW PATIENT FORMS

Please remember to:

- ❏ Bring your Driver's License/Government-issued ID and insurance card to your visit.
- ❏ Arrive 15 minutes prior to your scheduled appointment time.
- ❏ Complete attached forms thoroughly. This will help us with the registration process and help reduce your wait time.

Location: Located on the corner of Shaw and Teilman right in front of the stop sign on the corner. Cross between Fruit and West.

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PATIENT INFORMATION

Your health is of utmost importance to us. To assist with your evaluation, please fill out this form as accurately as possible. All information will be treated with confidentiality.

Last Name:_____ First Name: _____ MI:_____

Date of Birth: _____-_____-_____ SSN: _____-_____-_____ Sex: Male _____ Female _____ Other _____

Address: _____ City: _____ State: _____ Zip:_____

Patients lives in: ___ Home ___Group Home _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____

May we contact you at home? ____Yes ____ No May we contact you at work? ____ Yes ____ No

Emergency Contact: _____ Phone Number: _____-_____-_____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

Spouse Name: _____ Spouse Number: _____-_____-_____

Parent/Guardian Name: _____ Parent/Guardian Relationship: _____

Parent/Guardian Number: _____-_____-_____ DOB: _____-_____-_____ SSN: _____-_____-_____

Parent/Guardian Address: _____

Prefered Language: _____ Employer: _____

Race:

- ❑ Caucasian or white
- ❑ Black or African American
- ❑ Asian
- ❑ Native Hawaiiand or other Pacific Islander
- ❑ American Indian or Alaska Native
- ❑ Hispanic or Latino
- ❑ Other _____

Is this visit due to an accident of any kind? Yes _____ No _____

Explain: _____

_____

_

Are you covered by an employer's health insurance plan or that of a family member? _____ Yes _____ No

Patient/Guardian Signature: _____ Date: _____

Patient Rights and Responsibilities Statement

Patients have the right to:

Be treated with dignity and respect.

Be treated fairly, regardless of their race, gender, ethnicity, age, disability, or source of payment.

Have their treatment and other member information kept confidential. Only where permitted by law may records be released without member's permission.

Easily access care in a timely fashion.

Know about their treatment choices. This is regardless of cost or coverage by their benefit plan. Share in developing their plan of care.

Receive information in a language they can understand.

Receive a clear explanation of their condition and treatment options.

Receive information about clinical guidelines used in providing and managing their care. Ask their provider about their work history and training.

Know about advocacy and community groups and prevention services.

Right to refuse treatment.

Freely file a complaint or appeal and learn to do so.

Know of their rights and responsibilities in the treatment process. Request certain preferences in a provider from your insurance company.

Receive a copy of HIPAA Disclosures. I have received, read, and understand this disclosure.

Patient/Responsible Party Signature: _____ Date: _____

AUTHORIZATION FOR MEDICAL TREATMENT, STATEMENT OR RESPONSIBILITY, ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES, PATIENT RIGHTS & RESPONSIBILITIES. CANCELATION POLICY.

Patients Name: _____ Patients DOB: _____

Please initial to confirm you have read each policy.

_____ **Authorization for Medical Treatment:** I authorize the psychologist(s), therapists(s), their Assistance and/or designees in charge of my medical care to administer any treatment as my be necessary or advisable in my diagnosis and treatment at Impact Behavioral Recovery & Care (IBHRC). This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy. I also authorize copies of the medical records to be released to other physicians and healthcare facilities deemed necessary by any psychologist(s), or therapist(s) whose care I am under.

_____ **Statement of Responsibility:** I understand that I am financially responsible to IBHRC as a patient, parent, guardian, and conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, or out-of-pocket expenses.

_____ **Notice of Privacy Practices:** I have been given the opportunity to review IBHRC's Notice of Privacy Practices for Protected Health Information. I understand that IBHRC has the right to change the Notice of Privacy Practices at any time and that I may obtain a current copy from IBHRC office during normal business hours.

_____ **Patients Rights & Responsibilities:** I have been given the opportunity to review the IBHRC's Patients Rights & Responsibilities. I understand that IBHRC has the right to change the Patients Rights & Responsibilities at any time, and that I may obtain a current copy at IBHRC office during normal business hours.

_____ **Cancellation/Reschedule Policy:** Please be advised that IBHRC requires a 48-hour prior notice on all appointment cancellations or appointments that require to be rescheduled.

_____ **Consent of Treatment:** I authorize IBHRC and its assistants to evaluate and treat me.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, or power of attorney, parent, or is duly authorized by or on the behalf of the patient to execute the above and accept its terms.

Patient/Guardian Signature: _____

Printed Name: _____ Date: _____

AUTHORIZATIONS FOR DISCLOSURE OF MEDICAL INFORMATION, CONSENT TO INFORM

Authorization for disclosure of Medical Information

With my initials below I authorize IBHRC to disclose protected health information about me to carry out treatment, payment and health care operations. Please refer to IBHRC Notice of Privacy practices for a more complete description of such uses and disclosures. I have the right to review the Notice for Privacy Practices at any time during office hours.

With my consent (please initial only <u>one</u> of the following paragraphs):

_____ IBHRC <u>may</u> call my home/and or cell phone to leave a message on my voicemail. IBHRC may send me mail or email to me in reference any time to assist the practice, in carrying out treatment, payment or operations such as appointment reminders, billing information, insurance and any call pertaining to my clinical care.

_____ IBHRC <u>may not</u> leave any voicemail messages on my voicemail or speak to anyone in my household other than myself.

I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations. I understand and have been provided with a notice of patient privacy handout that provides a more completed descotion of info and uses and disclosures, I understand that i have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the office and i must agree on the use and disclosure of my protected health information. A photocopy or fax of this content is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance.

Patient/Guardian Signature: _____ DOB: _____

Printed Name: _____ Date: _____

Who may we speak to regarding your treatment?

I give permission to IBHRC to release my private health information, including appointment day/time, to the following person(s); spouse, family member etc:

Individual Name: _____ Relationship/Number: _____

Individual Name: _____ Relationship/Number: _____

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Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks:
Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:
What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian.The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threaten or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substance
Therapists must report an admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Clients Signature (Client's Parent/Guardian if under 18) Date

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Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name _____ First Name _____MI _____
DOB _____/_____/_____
Client Address _____
Client Home Phone _____ Cell/Work Phone _____
Client Email Address _____

Patient Consent

I, _____, do hereby authorize the release of a copy of my mental health information to the person or facility below.

Sender

Name of Person/Facility _____
Phone _____
Address _____

Recipient

Name of Person/Facility _____
Phone _____
Address _____

Date of Authorization _____/_____/_____
Authorization to expire on _____/_____/_____ or upon the happening of the following event _____

Information to be Released

(Note: Request for release of psychotherapy notes cannot be combined with any other type of request.)

- My entire mental health record
- Only those portions pertaining to _____
  (Specific provider name and/or dates of treatment)
- Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as authorization for any other type of protected health information.)
- Other _____

Purpose of Information Release

- Further mental health care
- Disability Determination
- Legal Investigation
- Applying for insurance
- Vocational rehab, evaluation
- Payment of Claim
- At the request of the client
- Other (specify) _____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

If signed by a personal representative:

a) Print your name _____

b) Indicate your relationship to the client and/or reason and legal authority for signing

Patient is

- minor
- incompetent
- disabled
- deceased

Legal Authority

- parent
- legal guardian
- representative of deceased

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PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you ***must*** receive a copy of the signed authorization.
6. ***Special Instructions for completing this authorization for the use and disclosure of PSYCHOTHERAPY Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical test, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. *Such authorization must be separate from an authorization to release other medical records.*

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TELEHEALTH CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's Initials

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As a patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit. _____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between Impact Behavioral Recovery and Care and staff and _____.
(Patient's name)

_____ _____ _____
Patient or Legal Representative Signature Date/Time Relationship to Patient

_____ _____
Print Patient or Legal Representative Name Witness Signature Date/Time

Clinicians Initials

_____I certify that I have explained the nature of this agreement to _____ patient/patient's legal representative.(circle one)

_____I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

_____ _____

Healthcare Provider Signature Date/Time

***copy given to patient original placed in chart initial**

Optional National Emergency Crisis Language I understand that due to the state of the current national emergency crisis, telehealth is offered to appropriate patients in an effort to comply with federal and state mandates of isolation and social distancing as an effort to provide protection to everyone. The purpose of this form is to obtain your consent for a telehealth visit with one of our healthcare providers at the office of . The purpose of this visit is for the care of during the national emergency.

_____ _____ _____

Patient or Legal Representative Signature Date/Time Relationship to Patient

_____ _____

Print Patient or Legal Representative Name Witness Signature Date/Time