Referral and Face Sheet

Date of Referral (mm/dd/yyyy):	Date of Admission (mm/dd/yyyy):	Insurance #/Medicaid ID:	Record #:

Name:	Date of Birth (mm/dd/yyyy):
Address:	Phone #:

Email:	Gender:	Race:

Name of Person Completing Referral:	Person Completing Referral Phone #:	Person Completing Referral Email #:

Legal Guardian Information

Guardian Appointed (Yes/No):	Legally Responsible Person Name:

Legal Guardian Address:			
City:	State:	Zip Code:	Telephone Number:

Email:

Emergency Contact Information

Emergency Name:	Relationship:	Phone #:

Physician Name:	Physician Phone #:

Mental Health

Last Hospitalization:

Informed Consent Agreement for Service Delivery

Client Name: _____ Legal Guardian:

Date of Birth: ____/____/____ Client Record #: _____ Client Insurance #:

PROGRAM: After clear explanation of program structure, rules, and expectations, I (we) give consent for

_____ to receive

Clinical Assessment **Outpatient Therapy** **RBT-ADS**

from EXHALE INTEGRATIVE SERVICES, LLC. I (we) understand that this service is voluntary and that this consent may be withdrawn with written notification at any time. I (we) also understand that I have the right to refuse treatment and that this refusal shall not be used as the sole ground for termination or threat of termination of services unless the treatment is the only viable option available at Exhale Integrative Services.

I (we) understand that Exhale Integrative Services may contact me and leave a message by phone, email, or mail for the purpose of providing me with the services I (we) consented to receive. I (we) will notify Exhale Integrative Services about any preferences regarding communication.

INTERVENTIONS: I (we) agree to allow Exhale Integrative Services, LLC, staff to implement professionally accepted methods of intervention as indicated by the client's and program's mutually agreed upon therapeutic treatment goal/plans. It is the policy of Exhale Integrative Services that physical restraint of client and isolation time-out *will be avoided in every circumstance.*

In the case of an emergency where the staff member has exhausted verbal de-escalation techniques and a client 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.

POST-SERVICE FOLLOW-UP: I (we) agree to participate in a Exhale Integrative Services post-service follow-up evaluation to assess the effectiveness of services. I (we) understand that this evaluation may be conducted by phone, mail, or email.

TRANSPORT: I (we) give permission and consent for the client to be transported by his/her therapist/worker and other program personnel. Transportation allows the client to participate in outings, events, appointments, and transport to and from home and other program activities. I (we) give permission for transportation and release Exhale Integrative Services and its employees from any liability for accident/injury to the client.

FIRST AID / MEDICATION ADMINISTRATION: I (we) authorize Exhale Integrative Services to provide and render first aid assistance to the client as deemed necessary by trained and certified staff.

EMERGENCY CARE: I (we) authorize Exhale Integrative Services to obtain emergency medical, dental, or mental health care for this client, if needed, until such times that I (we) can be reached to authorize further care.

FINANCIAL RESPONSIBILITY: I (we) understand that all services are charged to me (us) and payment (or insurance co-payment) is due at time of service. If my (our) insurance is to cover costs, I (we) will work in advance with Exhale Integrative Services to file the necessary forms. I (we) understand that Exhale Integrative Services may discharge me (us) from services for non-payment at any time.

INSURANCE: I (we) authorize Exhale Integrative Services to 1) release to insurance carriers necessary information regarding services provided by Exhale Integrative Services, and 2) process insurance claims generated in the delivery of services, and 3) receive insurance benefits, including third party reimbursement.

CLIENT'S RIGHTS: I (we) have been fully informed and/or have received a copy of the following documents:

1) **Notification of Privacy Practices**, 2) **Client's Rights**, and 3) **Client Handbook**, a summary of program policies and guidelines of Exhale Integrative Services.

AMENDMENTS: I (we) understand that this document may be amended, as needed, and that any such amendment will require the signature of the client or, if legally declared incompetent or being a minor, the legal guardian.

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.

Client: _____ Date:

Legal Guardian: _____ Date:

Authorization for the Disclosure and Reciprocal Exchange of Information

Client Name: _____ Client Record #:

Client Date of Birth: _____ /_____/_____ Insurance #:

I hereby authorize **Exhale Integrative Services, LLC** to disclose and receive specific client information about me by mail, electronic mail, fax, or other means in a reciprocal exchange of information with the following:

Person / Agency:

Address: _____ City: _____ State / Zip:

Phone: _____ Fax:

This data shall include (client initial by each type of information that may be released):

> Psychological Evaluation	> Diagnosis	> Alcohol / Drug Treatment*
> Psychiatric Evaluation	> Service Plan	> Hepatitis
> Screening	> Progress Notes	> Medication Information
> Client Profile	> HIV	> Financial Reimbursement
> UDS / Lab Results	> Other (please specify):	

** Client must sign, whether a child or adult; information protected by Federal Regulations 42 CFR part 2*

Purpose of the disclosure: X Assist with treatment X Referral ___ At Request of Client

___ Other:

I hereby acknowledge that Exhale Integrative Services, LLC, 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 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 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from disclosing it. North Carolina General Statutes 122C-53 through 122C56 indicate the exceptions that allow providers to break confidentiality and re-disclose records. The Exhale Integrative Services Client Handbook describes the circumstances where disclosure is permitted or required by state or federal laws. Other laws, however, may prohibit disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), this organization informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. In the following cases, minors have the same rights as adults and have the right to release information without a parent's signature: emancipated minors, minors receiving substance abuse treatment, and/or minors receiving treatment without parental consent. Documentation of record releases is kept in the client chart.

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.

Client/Legally Responsible Person:

Witness (not required): _____ Relationship to Client:

Date:

I have received a copy of this form.

client initials

This authorization is hereby revoked as of the date noted below:

Client / Legally Responsible Person: _____ Date:

The client and/or legally responsible person has notified me verbally that he/she wishes to revoke this authorization as of the date noted below:

Exhale Integrative Services Staff: _____ Date:

Agreement of Exhale Integrative Services No Show Policy

For Basic Services, if a client does not show for 2 appointments or cancels within 24 hours of the appointment twice within a period of 6 months, the client may not be scheduled for a follow-up appointment for a period of 6 months. If clients are not seen at least twice for 6 months, they will be discharged from Exhale Integrative Services.

For Enhanced Services, if a client does not show for 3 appointments or cancels within 24 hours of the appointment twice within a period of 6 months, the client may not be scheduled for a follow-up appointment for a period of 6 months. If clients are not seen at least twice for 6 months, they will be discharged from Exhale Integrative Services.

- As a client at Exhale Integrative Services, I agree to the above policy.

Client: _____ Date:

Legal Guardian: _____ Date:

Informed Consent to Participate in Telepsychiatry

Client Name: _____ Legal Guardian:

Date of Birth: _____ Client Record #: _____ Client Medicaid #:

1. I understand that I will be receiving mental health services through videoconferencing and that, at this time, there are no risks involved with receiving my care in this way.
2. I understand that I will be seen by a medical provider who is employed or contracted with Exhale Integrative Services and providing service from a remote location in North Carolina.
3. I am fully aware of the role of the medical provider and of the staff providing follow-up or on-going care.
4. My clinician/case manager has explained to me the equipment, how the videoconferencing technology will be used, and has answered all my questions concerning telepsychiatry.
5. I understand that my participation in telepsychiatry is voluntary, and I may refuse to participate or decide to stop participation at any time. I have been made aware of the alternatives including any delays in service, need to travel and the risks associated with not having the services provided by telepsychiatry.
6. I understand that my privacy and confidentiality will be protected in accordance with state and federal law when I am receiving services via telemedicine. I understand that I will be notified as to who is in the room at the hub site and that I have the right to exclude anyone from either site.
7. I understand that I have the right to appropriately trained staff immediately available to me while receiving telepsychiatry services to attend to emergencies or other needs.

Amendments: I (we) understand that this document may be amended, as needed, and that any such amendment will require the signature of the client or, if legally declared incompetent or being a minor, the legal guardian.

Acceptance: I (we) have read this document and I hereby consent to participate in receiving mental health services via telepsychiatry under the terms described above.

Check the appropriate box below.

I agree to participate in and receive psychiatric consultation via telemedicine.

I have chosen not to participate in telemedicine sessions.

Client: _____ Date:

Legal Guardian: _____ Date:

Witness: _____ Date:

Providers Choice

Client Name: _____ Legal Guardian:

Date of Birth: _____ Client Record #: _____ Client Medicaid #:

I acknowledge that I have been given an opportunity to review a list of Endorsed Service Providers and the services they provide. I understand that only medically necessary services will be authorized. I have been informed of the appropriate and available providers in the MCO/LME Provider Network that would meet my specific needs for services, location and hours of availability.

□ I understand it is my choice to select an Endorsed Service Provider to address my need and that I can alert my service provider if I would like to make a change.

□ I do not have a preference of Service Providers and understand that I will be referred to the next appropriate Service Provider on the LME/MCO Intake/Referral list.

□ I choose to receive services from Exhale Integrative Services and understand that someone from the agency will be contacting me within seven days from the date of my signature on this form to initiate the service process.

□ I choose to wait for the first available appointment for services to be provided by a different agency. I have received procedures for accessing crisis services and understand the risk of delaying services.

□ I choose to decline the recommended services at this time. I have received procedures for accessing crisis services and understand the risk of declining these services

Client: _____ Date:

Legal Guardian: _____ Date:

Treatment Planning Participation

Client Name: _____ Legal Guardian:

Date of Birth: _____ Client Record #: _____ Client Medicaid #:

I _____, agree to work with Exhale Integrative Services Therapist on treatment goals that we have developed during the treatment planning and or Clinical Assessment time.

Client: _____ Date:

Legal Guardian: _____ Date:

Consent to Work with Exhale Integrative Services Intern

Client Name: _____ Legal Guardian:
Date of Birth: _____ Client Record #: _____ Client Medicaid #:

I_____ (Client/Legal Guardian Name), willingly and voluntarily provide my consent to engage in therapeutic services with Exhale Integrative Services. I acknowledge that I have been informed about the nature of the services offered and the qualifications of the Clinical Student Intern assigned to work with me.

I understand that the Clinical Student Intern is currently enrolled in an accredited graduate program and is working towards completing internship hours for licensure in a mental health field. I am aware that the intern will be supervised by licensed Clinical Intern Supervisors and professors in their graduate program.

I consent to the collection, use, and disclosure of information shared during therapy sessions for the purpose of treatment, supervision, and as required by law. I understand that confidentiality is maintained within the limits of the law and that discussions between the intern and supervisors are also confidential.

I am aware that fees for therapy sessions contribute to the professional development of the intern, covering costs such as supervision, professional headshots, consultations, and training.

I have had the opportunity to ask questions and seek clarification about the therapy process, fees, and any other relevant information. I am entering into this therapeutic relationship voluntarily and with the understanding that I can withdraw from services at anytime

By signing below, I confirm that I have read, understood, and agree to the terms outlined in this Consent to Work with Exhale Integrative Services.

Legal Guardian/Client's Full Name: _____

Legal Guardian/Client's Signature: _____

Date: _____