Affinity Clinical
Programs that make a difference.

Medical Record Face Sheet

Patient Demographic Information		
Full Name: Preferred Name, if different:	Primary Contact Number:	
Age: DOB: Race:	Marital Status: □Single □Married □Divorced/Separated □Widowed	
Insurance: ☐Private ☐Medicaid ☐Self Pay ☐Medicare	ID/ Policy Number:	
Social Sec #:	Place of Birth:	
Height: Weight:	Distinguishing Marks:	
Primary Language: Religion: □Male □Female □Other/ Do not wish to disclose	Allergies: Medical Conditions: DSM Diagnosis:	
Physical Address:	City:	Zip:
Mailing Address, *if different*:	City:	Zip:

Referral Information

Please tell us your reason for Referral/ Presenting Problems:

Referred by : ☐Self ☐Healthcare Provider ☐Community Agency *(i.e: Social Services, DJJ, MCO/LME, School)* ☐Other

Accommodations:

Are there any learning or communication barriers to be aware of or needs to accommodate: ☐Yes ☐No

Details:

☐Assessed, None to Report

Safety Risks *This section is required. **(Describe environmental and behavioral safety concerns identified for potential service recipient and/or staff)**
Include risk related to detox, suicide, and/or homicide safety risks

☐Assessed, None to Report

Emergency Contact Information

Name:	
Physical Address:	Primary Phone:
Mailing Address, *if different*:	Secondary Phone:
☐Under 18 or Other Legally Responsible Party (LRP) identified**	
LRP Full Name:	Relationship to Patient: ☐Mother ☐Father ☐Guardian ☐Other
LRP Address *if different*:	Primary Contact Number:

Physician Information

Physician Name	Specialty	Address	Telephone Number	Last Date Seen

Brief Medical History:	
Current School	Grade Level
Pertinent Medical Issues:	

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Verification of Client Rights

* **This consent will automatically expire in one year provided that all claims for treatment have been paid as provided in any benefit plan***

_____	_____
Client Signature	Date
_____	_____
Parent/Legal Guardian Signature	Date
_____	_____
Witness Signature	Date

CONSUMER FINACIAL AGREEMENT

Consumer Name: _____ MR # _____

Address: _____

_____

County: _____ Telephone #: _____

SSN: _____ DOB: _____

I have the following insurance ***(please attach a copy of the insurance card):***

[ ] Medicaid / Medicaid #: _____

[ ] NC Health choice / Health choice # : _____

[ ] Other / Number: _____

[ ] No insurance

Please initial all that applies:

I understand that my insurance will be billed directly. However, if I have a co-pay that is required, such payment is due on or before the 1st day of each month I and/or my child receives services:
Initials: _____

I agree to notify Affinity Clinical Services within **24 hours** of discovering a change with my insurance.
Initials: _____

I understand that if there is a termination of my insurance for any reason, Affinity Clinical Services shall attempt to assist me in resolving this matter. However, if the matter is unable to be resolved, Affinity Clinical Services shall assist me in transitioning to other services available to me.

Initials: _____

I agree to notify Affinity Clinical Services at least 24 hours in advance if I am unable to make a scheduled appointment.
Initials: _____

_____ **_____**

Client / Guardian Signature / Date **Qualified Professional Signature / Date**

I certify that I have received a copy of this Client Rights/Grievance Policy. Affinity clinical services verbally explained my rights concerning client's right, privacy of information and grievance process. I understand these rights are design to protect my privacy.

X Client's Signature:_____ Date:_____

Parent/legal Guardian _____ Date _____

Parent/ legal Guardian _____Date _____

Staff / Counselor's Signature/Credential: _____ Date: _____

Telehealth and Tele therapy Declaration of Policies and Procedures

TO CLIENT(S), This Tele Health Policy and Procedure document describes certain important aspects of therapy unique to Telemedicine and Teletherapy (i.e., Telehealth). The Well Clinic is providing you this information for your review and agreement. Please read it carefully and discuss any questions you have before signing below.

Telehealth or Telephone services are covered when all of the following criteria are met:

1. The patient is present/participates at the time of service.
2. Services should be similar to in-person services with a patient.
3. Services must be medically necessary and otherwise covered under the member's benefit booklet or subscriber agreement.
4. Services must be within the provider's scope of license.
5. A permanent record of the telephonic communication(s) must be documented/maintained as part of the patient's medical record. It must be sufficiently documented to support the code used.
6. Consistent with NCDHHS/Cardinals Guideline will allow non-HIPAA compliant technology such as FaceTime and Skype to be used with discretion and patient consent.
7. Only the provider rendering the services may submit for reimbursement for telehealth services.

Limitations/Exclusions The following services are excluded from reimbursement:

1. Services rendered through email, text or by fax.
2. Telemedicine that occurs the same day as a face-to-face visit, when performed by the same provider and for the same condition. Services rendered within the past 7 days or 24 hours after telehealth/telemedicine visits will be considered bundled.
3. Patient communications incidental to E&M services, including, but not limited to reporting of test results or provision of educational materials.
4. Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

CLIENT RESPONSIBILITIES All clients, whether in person or via telehealth care should:

- Avoid using mind altering substances prior to session
- Dress appropriately during sessions
- Not bring any weapons of any kind to session
- Not record sessions without first obtaining the therapist's approval

All telehealth clients should:

- Be in an area that is safe and provides privacy.
- Be in an area that is appropriate for a web-based session, such as a home office, a nurse's station, etc.
- Not have anyone else in the room unless you first discuss it with your clinician
- Not conduct other activities while in session, such as driving
- Be located within the state of Louisiana or in a state in which the treating professional is licensed
- If a minor, have a parent or guardian with them at the location/building of the telehealth session, unless otherwise agreed upon with the therapist and client.

POTENTIAL COUNSELING RISKS When using technology for communication of any kind, there is a risk that it may be forwarded, intercepted, circulated, stored, or even changed and the security of the devices used may be compromised. Although we make reasonable efforts to protect the privacy and security of all electronic communications with you, it is not possible to completely secure the information. If you use any other methods of electronic communication with us, other than the means recommended by us, there is a reasonable chance that a third party may be able to intercept that communication. With the use of technology, it is important to be aware that family, friends, co-workers, employers, and hackers may have access to any technology, devices, or any other device you know is safe. You are responsible for reviewing the privacy sections and agreement forms of any application and technology you use. Please contact us with any questions that you may have on privacy measures.

OFFICE PROCEDURES AND FEES Along with the office procedures and fees listed in your clinician's declarations of practices and procedures, the following office procedures are being added as they relate to telehealth care:

FEES All fees for telehealth services will be collected the day before the service when staff calls to confirm the appointment.
Initial Appointments and Follow-Up Appointments Initial appointments must be in-person for both medical and psychological/counseling services. The only exception is when the area in which the client lives is in a declared "state of emergency," during which initial appointments can be conducted via telehealth services. In a declared "state of emergency," The Affinity Clinic Therapist reserve the right to decline initial intakes if such appointments hinder the care provided to existing clients/patients.
No-Show/Cancellations A fee will be charged for all unkept appointments or cancellations within 24 hours of the session. Please see the No-Show/Cancellation Fee Policy provided to you in your initial paperwork. If you are receiving services through Telehealth Care, you are expected to initiate the meeting at your schedule time. If the session is not initiated within 5 minutes of the start time for medical appointments and 10 minutes start time for therapy, the session will be considered a no-show and you will be charged for the session according to the No-Show/Cancellation Fee Policy.
On-Site sessions are held in The Affinity's administrative office, which is designed for privacy. Any information with your personal information is kept in a locked cabinet behind a locked door.
Your online information may be stored in a lock file in the secure medical record room.

Email
Email is not always secure. However, we have chosen to use Google Suite which is designed for privacy and security and provides a Business Associates Agreement for HIPAA compliance.
Verification of Identity If Telehealth sessions are requested, verification of identity will be required by matching you with your picture ID. If Telehealth sessions are conducted over the phone, you will choose a passphrase or number which you will use for all future sessions. This process protects you from another person posing as you.
CONSENT TO TELEHEALTH AND/OR TELETHERAPY TREATMENT
I have read The Affinity's Declaration of Telemedicine and Teletherapy Policies and Procedures and my signature below indicates my full informed consent to services provided by my clinician via telehealth treatment. I understand that my treating clinician should be and is trained accordingly as determined by his/her licensing board. If my clinician is a counseling student intern or a first year Provisionally Licensed Professional Counselor, this form of treatment will only be used in the case of a "state of emergency." In such cases, this consent and form of treatment will end on the date the "state of emergency" is no longer in effect.

X Initial ONE of the following:

____ (initials) I agree to participate in a telehealth consultation for the above procedure OR
____ (initials) I refuse to participate in a telehealth consultation for the above procedure
____ (initials) I agree to participate in a telehealth consultation and face to face for the above procedure

Client Signature:_____ Date:_____
Client Signature:_____ Date:_____
Clinician Signature:_____ Date:_____

Parental Authorization for Minors
I, _____, give permission for Affinity Clinical Services
[Parent's Name]
to conduct counseling with my _____, _____.
[Type of Relationship] [Name of Minor]
This information has been disclosed to you from records projected by Federal confidentiality rules (42CFR Part 2). The Federal rules prohibit you from making any further discloser of this information unless further discloser is expressly permitted by the written consent of a person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Verification of Consumer Choice

Affinity Clinical Services is committed to ensuring that the Persons Served have the right to choose the application of the service for which they qualify, to decide the provider of the services for which they qualify, and to select, if they desire, a change in services and/or providers.

By signing this form, you are stating you understand that you, as the Person Served, have the right to choose relevant services and which provider delivers those services and that Affinity Clinical Services has provided you that choice. Further, you acknowledge that no Affinity Clinical Services employees have, in any way, advertently or inadvertently influenced your choice of services or providers.

Service	Chosen Provider	Service	Chosen Provider
Assertive Community Treatment Team (ACTT)		**Psychosocial Rehabilitation**	
Child and Adolescent Day Treatment		**Substance Abuse Comprehensive Outpatient Treatment**	
Community Support Team		**Substance Abuse Intensive Outpatient Program**	
Diagnostic Assessment/Clinical Assessment		**Targeted Case Management**	
Intensive In-Home			
Mobile Crisis			
Multisystemic Therapy			
Outpatient Treatment	Affinity Clinical Services, PLLC	**Assessment, individual or family, Therapy**	
Partial Hospitalization			

I understand that Affinity Clinical Services has not influenced my decision in any way.

X_____ X_____

Person Served/ or Legal Guardian Signature Date

_____ _____

Witness Signature Date

Authorization for Use and Disclosure or Exchange of Protected Health Information

45 C.F.R. Parts 160 and 164; 42 C.F.R, Part 2; G.S. 122C

This authorization from implements the requirements for client authorization to use and disclose health information protected by federal health privacy law (45 C.F.R. parts 160, 164) the federal drug and alcohol confidentiality law (42 C.F.R. part 2) and the state confidentiality law governing mental, developmental disabilities, and substance abuse services (G.S. 122 C).

I, _____, **authorize** Affinity Clinical Services, PLLC 5624 Executive Center Dr. Ste. 105 Charlotte, 28212

Person Served or Person Served legal representative — Agency or person authorized to use/disclose the information

to use or disclose to: _____

Agency or Person to whom the requested use, exchange or disclosure will be made

Specific meaningful description of the information to be used/disclosed

Please check the following protected information to be released for the date of service indicated above. The disclosure of information or data may include paper, oral and electronic interchange:

☐ Entire Medical Record (Does not include HIV/AIDS testing, genetic testing or drug and alcohol information).To authorize the disclosure of this information, you must also check or initial below)

☐ Alcohol and drug treatment information	☐ HIV/AIDS/ARC information	☐ Discharge Plan/Summary ☐ Diagnosis
☐ Psychological testing/Evaluation Report	☐ Urine Screens/lab results	☐ Therapy Notes ☐ Progress Notes
☐ Individualized Treatment/service Plan	☐ Billings/Financial Statements	☐ Diagnostic/comprehensive assessment
☐ written letter/correspondence	☐ Medication	☐ Medical History ☐ Attendance
☐ Psychiatric Diagnostic Evaluation	☐ Verbal communication	☐ Other_____

The purpose of this disclosure is (please check or initial in spaces that apply)

☐ At the request of the individual	☐ Coordination of Services	☐ Court Proceedings	☐ Continuity of Care
☐ Assessment/Evaluation request	☐ Determination of Benefits	☐ Audit Purpose	☐ Other_____

I understand information regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS or Human Immunodeficiency Virus (HIV)*

REDISCLOSURE: Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law (45CFR 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. When this agency disclosed mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42CFR Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION: I understand that, with certain exceptions, I have the right to revoke this authorization at any time. However, your revocation will not be effective to the extent that Affinity Clinical Services has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurance coverage and the insurer has a legal right to contest a claim. If I revoke this authorization, I must do so in writing. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in Affinity Clinical Services Notice of Privacy Practices, a copy of which has been provided to me.

If not revoked earlier, this authorization expires upon: _____

(Not to exceed one year from date of signature)

NOTICE OF VOLUNTARY AUTHORIZATION: I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Affinity Clinical Services cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

_____ _____ _____

Signature of Person Served — Date — Please Print Name

_____ _____

Signature of Legally Responsible person/personal representative if required. — Date

Please explain representative's authority to act on behalf of Person Served: _____

Advance Directives

What is Psychiatric Advance Directive?

You have the right to make instructions for your treatment in advance. North Carolina has two laws that govern psychiatric Advance Directions (PAD): G.S. 122C-71 through 77 and G.S. 32A-15 through 25.
What is an "advance directive"? An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."
Advance Directive for mental healthcare/substance abuse is a legal document that provides instructions for mental health treatment you would want to receive if you are in crisis and unable to communicate for yourself or make voluntary decisions. The instructions make statements about what you think calms you down, how you feel about seclusion or electric shock, what medicines you do and do not want to take, and which doctor you want to be in charge of your treatment. These are decisions you make in advance to be followed by a physician or psychologist. Your instructions may be overridden if you are held involuntarily committed. A description of the state and Federal laws outlined in the Medicaid Special bulletin on Advance Directives, May 1999 can be found at:
https://www2.ncdhhs.gov/dma/Forms/advdirective.pdf
or the attached two-page printed copy provided to you
We will be glad to know if you would need to have someone in our staff explain to you how you can get advance directive prepared. Please check one

___Yes, I need help with advance directive

___ No, I have no desire to have advance directive explained and referral made for me or a member of my family.

Signature: _____ Date: _____

This document becomes part of the Person Served' s permanent file.

Assessment Signatures

I/My family participated and provided information necessary to complete this assessment. I have reviewed the assessment and understand that this information will be used to guide further treatment plans and service recommendations.

	SIGNATURE	**DATE**
Patient Signature: (Adolescent Only)		
Patient/Responsible Party Signature**:**		
Clinician's Signature and Credentials:		
Clinician's Printed Name/Credential/Title:		
Nurse Practitioner Signature:		

TREATMENT PLAN SIGNATURES

Person receiving services:

- I confirm and agree with my involvement in the development of the person centered plan. My signature means that I have reviewed and agree with the services and/supports to be provided.
- I understand that my service plan can be reviewed with me at any time during course of my treatment when initiated by me or my therapist but at a minimum of one time per year.
- I understand that I have the right to choice of services providers and may change service providers at any time, by contacting the person responsible for my plan.

Client Signature: _____ Date: _____

Parent/ Legal Guardian Signature: _____ Date: _____

Person Responsible for Plan: _____ Date: _____

Other Team Member Signature: _____ Date_____