



Consumer Name:
Record Number:

D.O.B:
Medicaid:



CONSUMER FACE SHEET

Date of Intake: __/__/__ Date of Assessment: __/__/__

Consumer First Name: _____ Middle Initial: ____ Last Name: _____ Maiden Name: _____

Preferred Name/Nickname: _____

Birth Place: _____ Age: ____ Sex: _____ Race: _____

Soc. Sec. Number: _____ Marital Status: _____

Religious Preference: _____ Sexual Preference: _____

Consumer Address: _____ State: ____ City: _____ Zip: _____

Medicaid #: _____ Health Choice #: _____ Medicare: _____

Other Insurance: _____ See pg 2 to list detailed information re: private insurance

Phone (Home): _____ Phone (Cell): _____ Other: _____

Language Preference (if other than English): _____

If School Age list name of School: _____ Grade Level: ____

Highest Level of Education: _____ Military Status: _____

Occupation: _____ Duration of Employment at current occupation: ____

Does client require a legal guardian Yes ☐ No ☐

IF Yes:

Name of Legal Guardian: _____

Legal Guardian Address: _____

State: ____ City: _____ Zip: _____

Phone (Home): _____ Phone (Cell): _____ Other: _____

PARENTS: Father: _____ Marital Status: _____
Address: _____ SSN #: _____

Telephone: _____
Mother: _____ Marital Status: _____
Address: _____ SSN #: _____

Telephone: (_____) _____

Stepfather's name: _____

Stepmother's name: _____

Siblings: Age: Sex: Address _____

Services Needed: Psychosocial Rehabilitation Services ☐ Peer Support ☐ SAIOP ☐ Supportive Employment ☐

Therapy ☐ Residential Services ☐



Consumer Name:
Record Number:

D.O.B:
Medicaid:



Referral Statement

Referent's Name: _____ Gender: ☐ Male ☐ Female: Age: _____

Emergency: ☐ Yes ☐ None-emergency: ☐ YES in case of emergency, was there a TDO: ☐ Yes ☐ No

SSN: _____ DOB: _____ Medicaid#: _____

MCO Name of Caller: _____ Relationship to Referent: _____

Current place of address: _____ Phone Number: _____

FOR ALL other services tried/explored within past 30 days (i.e., CSB, CPS, Stabilization, DSS, Judiciary, or other mental health. List names, contact information etc.)

SA PHP Hospitalization required: name and dates of discharge from Psychiatric hospital or other facility i.e. residential crisis stabilization, ICT or PACT services; psychiatric residential treatment facility; TDO, etc.:

Psychotropic Medications prescribed in last 12 months:

___ Best method of contact: ☐ Phone ☐ In-Person ☐ Email ☐ Fax Date of Initial contact _____

Projected date of assessment Interview: _____ Anticipated date of admission: _____

Why are services needed? (Specific symptoms being displayed by referent within past 30 days include frequency, duration, and intensity, i.e., anger problems- describe behavior).

Referent's Disposition:



Consumer Name:
Record Number:

D.O.B:
Medicaid:



HIPAA Notice

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) consists of two Titles. Title I protects health insurance coverage for workers and their families when they change or lose their jobs. Title II requires the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and addresses the security and privacy of health information. HIPAA was first proposed with the simple objective to ensure health insurance coverage after leaving a job. In addition to these portability provisions, however, Congress added an Administrative Simplification section, with the goal of saving money in mind. The Administrative Simplification section was requested and supported by the health care industry because it standardized electronic transactions and required standard record formats, code sets, and identifiers.

Following this standardization effort, Congress recognized the need to enhance the security and privacy of individually identifiable health information in all forms. In 1999, Congress directed the Department of Health and Human Services (DHHS) to develop privacy and security requirements in accordance with HIPAA Title II.

Privacy Rule

The Privacy Rule is a federal regulation defining administrative steps, policies, and procedures to safeguard individuals' personal, private health information (protected health information or PHI).

The Privacy Rule is designed to empower patients by guaranteeing them access to their medical records, giving them more control over how their PHI is used and disclosed, and providing a clear avenue of recourse if their medical privacy is compromised. The rule is designed to protect medical records and other personal health information maintained by certain health care providers, hospitals, health plans, health insurers and health care clearinghouses.

Who must comply with the Privacy Rule?

The following types of health care organizations are defined as "covered entities" by the Privacy Rule:

- ☐ All health care providers who choose to transmit certain administrative and financial health information electronically.
- ☐ All health plans.
- ☐ All health care clearinghouses

What information is protected?

The rule defines "protected health information" as health information that:

1. identifies an individual
2. is maintained or exchanged electronically or in hard copy.

If the information has any components that could be used to identify a person, it would be protected. The protection would stay with the information as long as the information is in the hands of a covered entity or a business associate. The protections apply to individually identifiable information in any form, electronic or non-electronic. The paper progeny of electronic information is covered (i.e. the information would not lose its protections simply because it is printed out of a computer), and oral communications are also covered.

I UNDERSTAND THE ABOVE NOTICE ON HIPPA THAT HAS BEEN READ AND EXPLAINED TO ME BY A MEMBER OF THE TREATMENT FACILITY STAFF, AND I HAVE RECEIVED A COPY OF THIS NOTICE.

Signature of Consumer/Guardian

Date

Witness Signature

Date



Consumer Name:
Record Number:

D.O.B:
Medicaid:



NOTICE OF PRIVACY PRACTICES

This describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

All information that is provided during the screening, referral, admission, and treatment/habilitation process is considered confidential by the employees, interns, and volunteers of Creative Directions Behavioral Health Services.

Information obtained about you during the screening and referral process may be shared with the provider from whom you have chosen to receive services.

Information obtained about you by a psychiatrist, therapist, case manager, nurse or other member of your treatment team will be recorded in your record and used to determine the course of treatment that should work best for you.

Treatment team members will also be expected to collaborate on developing your person-centered plan and to discuss your progress in treatment on a routine basis.

Information about the services you receive may be submitted and processed by the Authorization and/or Billing departments so that your provider can be paid for your services.

Documentation from your medical record may also be pulled for review by the Quality Improvement or Authorization departments in preparation for an audit or for other reviews to improve the quality and effectiveness of the services you receive.

Other disclosures of protected health information outside of Creative Directions Behavioral Health Services are permitted when you or your legal representative signs a written authorization or gives verbal authorization in an emergency situation.

Any authorization for disclosure may be revoked at any time, except to the extent that action has been taken in reliance on it.

You have the right to request restriction of the disclosure of your health information, except when Creative Directions Behavioral Health Services is required to do so.

Signature of Consumer/Guardian

__ / __ / __
Date

Witness Signature

__ / __ / __

Date



Consumer Name:
Record Number:

D.O.B:
Medicaid:



NOTICE OF PRIVACY PRACTICES cont....

Under the following specific conditions, disclosure of information outside of Creative Directions Behavioral Health Services is permitted and/or required by law and professional ethics without your specific authorization:

- 1) When there is a medical or psychiatric emergency involving your health or safety or the safety of others.
- 2) When Creative Directions Behavioral Health Services is required by law to report instances of neglect or abuse of a child or disabled adult.
- 3) When the disclosure is for judicial or administrative proceedings and OPC is responding to an order of a court or administrative tribunal.
- 4) When Creative Directions Behavioral Health Services authorizes research for the purpose of program planning and evaluation of services through the use of statistical information that cannot be linked to any individual.

The confidentiality of alcohol and drug abuse records maintained by this agency is protected by Federal Law and regulations, and violation of the Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Only Authorized staff member have access to this data.

I UNDERSATND THE ABOVE NOTICE OF PRIVACY PRACTICES THAT HAS BEEN READ AND EXPLAINED TO ME BY A MEMBER OF THE TREATMENT FACILITY STAFF, AND I HAVE RECEIVED A COPY OF THIS NOTICE.

Signature of Consumer/Guardian

____/____/_____
Date

Witness Signature

____/____/_____
Date



Consumer Name:
Record Number:

D.O.B:
Medicaid:



Consent for Treatment

I agree for _____ to participate in the treatment program provided by Creative Directions Behavioral Health Services. I understand that this treatment program may consist of one-on one individualized treatment, case management, individual and group therapy as well as outreach services. I am aware that treatment is clinical and is based on the presence of a medically defined diagnosis assigned by a Licensed Professional. Should the clinical staff determine placement is appropriate, I consent to treatment as deemed necessary.

I also understand that I will be informed of any changes in the service/treatment assignments and have the right to agree/disagree to any referrals to the above components prior to my loved on being placed in the program component, except in an emergency situation.

In case of accident or illness, I also give my consent for the facility/staff to provide and/or obtain emergency medical treatment.

I fully understand the above statements that have been read and explained to me by a member of the treatment facility staff.

Parent/Guardian/Custodian/Consumer may appeal any grievances to the Clinical Director by writing the Clinical Director and requesting a meeting in regards to questions or grievances. The meeting will be convened by the Clinical Director at a mutual time at the location of Creative Directions Behavioral Health Services.

Signature of Consumer/Guardian

____/____/____
Date

Witness Signature

____/____/____
Date

Permission to Bill Insurance Company

I, _____ authorize staff and the representative of Creative Directions Behavioral Health Services to bill the appropriate insurance company for services provided to me or for the (consumer's name) _____.

Signature of Consumer/Guardian

____/____/____
Date

Witness Signature

____/____/____
Date



Consumer Name:
Record Number:

D.O.B:
Medicaid:



Waiver

I, (print name) _____, understand that by signing this release, I waive any and all claims against Creative Directions Behavioral Health Services and/or its staff for any liability including but not limited to personal/bodily injury (including death) and consumer property loss or damage during involvement in any class or activity sponsored by Creative Directions Behavioral Health Services. Consumer participation is voluntary, so the undersigned acknowledges the risks of potential injury associated with the physical aspects of activity participation.

(Date)

(Signature of adult subject)

(Address)

(City, State, Zip)

WAIVER FOR MINOR CHILDREN (Under 18)

I, (print name) _____, parent or official guardian of (child's name) _____ understand that by signing this release, I waive any and all claims against Creative Directions Behavioral Health Services and/or its staff for any liability including but not limited to personal/bodily injury (including death) and consumer property loss or damage during involvement in any class or activity sponsored by Creative Directions Behavioral Health Services. Consumer participation is voluntary, so the undersigned acknowledges the risks of potential injury associated with the physical aspects of activity participation.

(Date)

(Signature of Parent or Guardian)

(Address)

(City, State, Zip)

Signature of Consumer/Guardian

____ / ____ / ____
Date

Witness Signature

____ / ____ / ____
Date



Consumer Name:
Record Number:

D.O.B:
Medicaid:



Authorization for Release of Information

Consumer Name: _____ Consumer D.O.B. ____/____/____ Consumer Social Security#: _____

I _____ (consumer/guardian) understand that this authorization is voluntary. I understand that my information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws.

I understand that my information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding obtain my criminal history any time during or before the course of my treatment – related information protected by the Public Health Law, section 2786 and Article 21, Title III (section 2139, Part 63). I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I understand that I may revoke this authorization at any time by notifying Creative Directions Behavioral Health Services in writing, but if I do, it will not have any effect on any actions Creative Directions Behavioral Health Services took before it received the revocation.

I hereby authorize Creative Directions Behavioral Health Services to **(Initial all that apply):**

Exchange with _____ Release to _____ Obtain from _____ the party I have indicated below:

I hereby authorize Creative Directions Behavioral Health Services to exchange / release / obtain information (Initial all that apply):

verbally only _____ in written form only _____ both verbally and in writing _____

Organization receiving/communicating the information:

Name: Creative Directions Behavioral Health Services

Please initial all appropriate information to be disclosed or released (***only initial items that are applicable to you**):

_____ Criminal History _____ Psychological Testing
_____ Drug Testing _____ Community Referrals
_____ District Court/Probation _____ Substance Abuse Information
_____ Other: _____

Please Note: Information obtained about you will be recorded in your record and used to determine the course of treatment that should work best for you. Information obtained will be used to collaborate on developing your person-centered plan and to discuss your progress in treatment on a routine basis.

Reason: Treatment

Purposes _____

Signature of Consumer/Guardian

_____/____/____
Date

Witness Signature

_____/____/____
Date

Expiration Date ____/____/____



Consumer Name:
Record Number:

D.O.B:
Medicaid:



Authorization for Release of Information

Consumer Name: _____ Consumer D.O.B. ____/____/____ Consumer Social Security#: _____

I _____ (consumer/guardian) understand that this authorization is voluntary. I understand that my information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws.

I understand that my information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding obtain my Medical any time during or before the course of my treatment – related information protected by the Public Health Law, section 2786 and Article 21, Title III (section 2139, Part 63). I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I understand that I may revoke this authorization at any time by notifying Creative Directions Behavioral Health Services in writing, but if I do, it will not have any effect on any actions Creative Directions Behavioral Health Services took before it received the revocation.

I hereby authorize Creative Directions Behavioral Health Services to **(Initial all that apply):**

Exchange with _____ Release to _____ Obtain from _____ the party I have indicated below:

I hereby authorize Creative Directions Behavioral Health Services to exchange / release / obtain information (Initial all that apply):

verbally only _____ in written form only _____ both verbally and in writing _____

Organization receiving/communicating the information:

Name: Creative Directions Behavioral Health Services

Please initial all appropriate information to be disclosed or released (***only initial items that are applicable to you**):

_____ Medical History _____ Psychological Testing
_____ Drug Testing _____ Community Referrals
_____ District Court/Probation _____ Substance Abuse Information
_____ Other: _____

Please Note: Information obtained about you will be recorded in your record and used to determine the course of treatment that should work best for you. Information obtained will be used to collaborate on developing your person-centered plan and to discuss your progress in treatment on a routine basis.

Reason: Treatment

Purposes _____

Signature of Consumer/Guardian

Date

____/____/____

Witness Signature

____/____/____

Expiration Date ____/____/____



Consumer Name:
Record Number:

D.O.B:
Medicaid:



Authorization for Release of Information

Consumer Name: _____ Consumer D.O.B. ____/____/____ Consumer Social Security#: _____

I _____ (consumer/guardian) understand that this authorization is voluntary. I understand that my information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws.

I understand that my information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding obtain my medical history any time during or before the course of my treatment – related information protected by the Public Health Law, section 2786 and Article 21, Title III (section 2139, Part 63). I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I understand that I may revoke this authorization at any time by notifying Creative Directions Behavioral Health Services in writing, but if I do, it will not have any effect on any actions Creative Directions Behavioral Health Services, LLC took before it received the revocation.

I hereby authorize Creative Directions Behavioral Health Services to **(Initial all that apply):**

Exchange with _____ Release to _____ Obtain from _____ the party I have indicated below:

I hereby authorize Creative Directions Behavioral Health Services to exchange / release / obtain information (Initial all that apply):

verbally only _____ in written form only _____ both verbally and in writing _____

Organization receiving/communicating the information:

Name: Creative Directions Behavioral Health Services

Please initial all appropriate information to be disclosed or released (***only initial items that are applicable to you**):

_____ Medical History	_____ Psychological Testing
_____ Drug Testing	_____ Community Referrals
_____ District Court/Probation	_____ Substance Abuse Information
_____ Other: _____	

Please Note: Information obtained about you will be recorded in your record and used to determine the course of treatment that should work best for you. Information obtained will be used to collaborate on developing your person-centered plan and to discuss your progress in treatment on a routine basis.

Reason: Treatment

Purposes _____

Signature of Consumer/Guardian

Date

____/____/____

Witness Signature

Date

____/____/____

Expiration Date ____/____/____



Consumer Name:
Record Number:

D.O.B:
Medicaid:



Authorization for Release of Information

Consumer Name: _____ Consumer D.O.B. ____/____/____ Consumer Social Security#: _____

I _____ (consumer/guardian) understand that this authorization is voluntary. I understand that my information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws.

I understand that my information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding obtain my medical history any time during or before the course of my treatment – related information protected by the Public Health Law, section 2786 and Article 21, Title III (section 2139, Part 63). I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I understand that I may revoke this authorization at any time by notifying Creative Directions Behavioral Health Services in writing, but if I do, it will not have any effect on any actions Creative Directions Behavioral Health Services took before it received the revocation.

I hereby authorize Creative Directions Behavioral Health Services to **(Initial all that apply):**

Exchange with _____ Release to _____ Obtain from _____ the party I have indicated below:

I hereby authorize Creative Directions Behavioral Health Services to exchange / release / obtain information (Initial all that apply):

verbally only _____ in written form only _____ both verbally and in writing _____

Organization receiving/communicating the information:

Name: Creative Directions Behavioral Health Services

Please initial all appropriate information to be disclosed or released (***only initial items that are applicable to you**):

_____ Medical History	_____ Psychological Testing
_____ Drug Testing	_____ Community Referrals
_____ District Court/Probation	_____ Substance Abuse Information
_____ Other: _____	

Please Note: Information obtained about you will be recorded in your record and used to determine the course of treatment that should work best for you. Information obtained will be used to collaborate on developing your person-centered plan and to discuss your progress in treatment on a routine basis.

Reason: Treatment

Purposes _____

Signature of Consumer/Guardian

Date ____/____/____

Witness Signature

Date

Expiration Date ____/____/____



Consumer Name:
Record Number:

D.O.B:
Medicaid:



Authorization for Release of Information

Consumer Name: _____ Consumer D.O.B. ____/____/____ Consumer Social Security#: _____

I _____ (consumer/guardian) understand that this authorization is voluntary. I understand that my information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws.

I understand that my information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding obtain my medical history any time during or before the course of my treatment – related information protected by the Public Health Law, section 2786 and Article 21, Title III (section 2139, Part 63). I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I understand that I may revoke this authorization at any time by notifying Creative Directions Behavioral Health Services in writing, but if I do, it will not have any effect on any actions Creative Directions Behavioral Health Services took before it received the revocation.

I hereby authorize Creative Directions Behavioral Health Services to **(Initial all that apply):**

Exchange with _____ Release to _____ Obtain from _____ the party I have indicated below:

I hereby authorize Creative Directions Behavioral Health Services to exchange / release / obtain information (Initial all that apply):

verbally only _____ in written form only _____ both verbally and in writing _____

Organization receiving/communicating the information:

Name: Creative Directions Behavioral Health Services

Please initial all appropriate information to be disclosed or released (***only initial items that are applicable to you**):

_____ medical History _____ Psychological Testing
_____ Drug Testing _____ Community Referrals
_____ District Court/Probation _____ Substance Abuse Information
_____ Other: _____

Please Note: Information obtained about you will be recorded in your record and used to determine the course of treatment that should work best for you. Information obtained will be used to collaborate on developing your person-centered plan and to discuss your progress in treatment on a routine basis.

Reason: Treatment

Purposes _____

Signature of Consumer/Guardian

Date ____/____/____

Witness Signature

____/____/____
Date

Expiration Date ____/____/____



Consumer Name:
Record Number:

D.O.B:
Medicaid:



IT IS YOUR RIGHT:

To be treated with **dignity** and *respect*
To be told about your treatment
To have a say in your treatment
To speak to others in private to have your complaints resolved
To say what you prefer
To ask question and be told about your rights
To get help with your rights
To appeal and to know appeal rights

If you have questions or need help, see the program contact person or contact the Regional Advocate:

Program contact person:

Leon Zimmermann III (434) 835-2370

HUMAN RIGHTS ADVOCATE:

Chelsea Robinette
SVMHI Office of Human Rights
1220 Bank Street
PO Box 1797
Richmond, VA 23218
Phone: 434-770-3636
Fax: 833-425-7159
Chelsea.robinette@dbhds.virginia.gov

Client/Guardian Signature & date:

Staff Signature & date: