Face Sheet

MR# (office only)_____ DOA: ___/___/____

Patient Information

Full Name (First, MI, Last): _____

Street Address: _____ Tel: _____

City: _____ State: _____ Zip: _____ Cell: _____

Date of Birth: ____/____/_____ Social Security: (Last 4 numbers) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Gender**: ☐ Male ☐ Female

Insurance Info:

☐ Medicare No: _____ ☐ Medicaid No: _____

☐ Other: _____ Managing Plan _____

In Case of Emergency

Name: _____ Relationship: _____
(Guardian or Personal Care Facility)

Street Address: _____ Tel: _____

City: _____ State: _____ Zip: _____ Cell: _____

Current Treatment Information

Are you currently under the care of a physician? ☐ Yes ☐ No

If Yes, physician's name: _____ Tel: _____

Medications: ☐ **Yes** ☐ **No**

For Office Personnel Only

☐ **New Admit** ☐ **Authorization** **Services:** ☐ **IOP** ☐ **Other**

Insurance: ☐ **Authorized** ☐ **Not Authorized**

Authorization Request Dates

1	**6**	**11**	**16**	**21**
2	**7**	**12**	**17**	**22**
3	**8**	**13**	**18**	**23**
4	**9**	**14**	**19**	**24**
5	**10**	**15**	**20**	**25**

Client Name: _____ MR# _____ DOA: ____/____/_____

CONSENT FOR TREATMENT-Outpatient Program

Please check to show your understanding and agreement to each of the following conditions of treatment:

_____**I, the undersigned hereby attest that I have voluntarily entered into treatment, or give my consent for the person under my legal guardianship mentioned above to enter treatment at Transitional Life Counseling &Consultations (TLCC)** Further, I agree to collaborate with **Transitional Life Counseling &Consultations (TLCC)** team members [consisting of psychiatrists, psychologists, general practitioners, ophthalmologists, nurse practitioners, licensed vocational nurses, social workers, counselors, or interns (under the supervision of stated-approved supervisors)] in optimizing my treatment benefits. The rights, risks and benefits associated with treatment have been explained to me. I understand that I may discontinue treatment at any time preferably in collaboration with the psychiatrist and treatment team members in order to ensure appropriate discharge planning for my community reintegration.

_____**Non-Voluntary Discharge from Treatment:** A patient may be terminated from **Transitional Life Counseling &Consultations (TLCC)** non-voluntarily, if: (A) the patient exhibits physically/verbally/sexually violating behavior toward others; (B) carries drugs or weapons; (C) engages in illegal activities at **Transitional Life Counseling &Consultations(TLCC)** and/or (D) refuses to comply with stipulated program rules or treatment recommendations. The patient and guardian will be notified of the non-voluntary discharge. The patient and guardian may appeal this decision with the treatment team or request to re-apply for services under a provisional plan.

_____**Patient Notice of Confidentiality:** the confidentiality of patient records maintained by **Transitional Life Counseling &Consultations (TLCC)** is protected by the Health Insurances Portability & Accountability Act of 1996 (HIPAA) and Federal/State law and regulations [*Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2)].* In general, **Transitional Life Counseling &Consultations (TLCC)** may not disclose to anybody who is not a member of the **Transitional Life Counseling &Consultations(TLCC)** treatment team except for the legal guardian: (A) any information concerning the presence/identity and or treatment of a patient in the program; (B) patient's drug/alcohol abuse information.

_____**I, as a patient or responsible party for patient, authorize treatment** by and payment of medical benefits by Medicare, Medicaid, and/or third party payer to **Transitional Life Counseling &Consultations(TLCC)** for psychological services rendered as ordered by the patient's physician. I understand the **Transitional Life Counseling &Consultations(TLCC)** accepts assignment" or insurance benefits assigned by Medicare and/or Medicaid. I authorize release of medical information necessary to process claims associated with my participation in therapy conducted by **Transitional Life Counseling &Consultations (TLCC)**

_____**Limitations to Confidentiality:** the laws of confidentiality yield to: (1) the patient or guardian's verbal or written consent to release, (2) court subpoenas, (3) a potentially dangerous situation to self or other, (4) medical personnel in a medical emergency, (5) law enforcers in a life/death emergency (6) law enforcers when a crime has been committed or a threat to commit a crime was made toward a staff or fellow patient at **Transitional Life Counseling &Consultations (TLCC)** (7) treatment team members' duty to warn a potential victim when an imminent threat has been made, (8) qualified personnel for research, audit, or program evaluation, (9) evidences of prenatal exposure to controlled substances or communicable disease to the Health Department, (10) suspected abuse of a minor or elderly to appropriate protective services.

_____ **I will not hold any of the staff, volunteers, directors and officers of Transitional Life Counseling &Consultations (TLCC) responsible for any injury to the above named member during the course of the Transitional Life Counseling &Consultations (TLCC) program.**

_____**I permit** a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Witness Date

Client Name: _____ MR# _____ DOA: ____/____/_____

Consent for Emergency Medical Care (Release of Information)

I, _____ on _____ hereby authorize
(*Print Patient's Name/Consenter*) (*Date*)

Transitional Life Counseling &Consultations (TLCC) to contact the below named person(s) in the event of a medical emergency.

Emergency Contact:

Name: _____ Phone Number: _____

Addresss: _____

Medical Facility to provide emergency care:

Name: _____ Phone Number: _____

Addresss: _____

Known drug allergies:_____

List of current medications/diseases:_____

The authorization will expire automatically in one year after the date noted below:

Signature of Patient: _____ Date: _____

Signature of Consenter: _____ Date: _____

Signature of Staff: _____ Date: _____

Client Name: _____ MR# _____ DOA: ____/____/_____

AUTHORIZATION FOR RELEASE OF INFORMATION
(VERBAL AND/OR VISITING CONSENT)

I, _____ ,on _____ hereby authorize
(*print patient's name*) (*date*)

Transitional Life Counseling and Consultation (TLCC) the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. Description of information:

_____ My presence in this facility.
_____ Physical status.
_____ My treatment process (such as psychosocial history, medical history, medication, lab, discharge planning, psychological testing, progress made, staffing).

Person to receive information:

Name: _____ Phone Number: _____

The purpose for this disclosure is: _____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician denying the provision of Healthcare.

I understand that this authorization will expire in 90 days.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

You have the right to revoke this authorization. To revoke this authorization, sign and date in the space provided below. By signing this revocation, I understand that this revocation will be effective today, except to the extent that *Transitional Life Counseling and Consultation (TLCC*) has already relied upon by authorization to use or disclose my health information as described in the Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Client Name: _____ MR# _____ DOA: ____/____/_____

Transportation Agreement

- I understand that in the event I am unable to arrange transportation, it may be provided for me, free of charge as a service of **Transitional Life Counseling & Consultations**.
- I agree that **Transitional Life Counseling & Consultations**, is to be released of any liability whatsoever that may arise from incidents or actions while boarding, disembarking, being transported by, **Transitional Life Counseling & Consultations** transportation services vehicles.
- I agree and give my permission to be transported to and from of **Transitional Life Counseling & Consultations** by a delegated transportation staff member.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date:_____

Client Name: _____ MR# _____ DOA: ____/____/_____

PROGRAM RULES

- I will make a commitment for my treatment to attend at least 5 days a week.
- I understand that the hours of the program are from 8:30am to 1:30pm.
- I agree to notify the transportation coordinator if I will not be attending.
- I understand that I am attending the **Transitional Life Counseling &Consultations (TLCC)**.
- I understand that treatment is important to stabilize and manage my symptoms.
- I agree to follow through with the course of treatment advised by my Physician and Therapist, who are acting in my best interest.
- I understand that **Transitional Life Counseling &Consultations (TLCC)** provides treatment for my disorder, and I consent to participate in my own treatment program.
- I agree to advise my therapist a day in advance, should I need to be absent.
- I understand that if I miss three (3) consecutive days of treatment (except for medical reasons), I will be counseled and could possibly be discharged from the program.

I, the undersigned, have read and I am in agreement with the above information, it has been explained to me in a language I understand. My signature below states that I am in agreement with them

Signature of Patient: _____ Date: _____

Signature of Witness/Staff: _____ Date: _____