Name: _____ Case #: _____

Type: Patient Assessment Medicaid #: _____ Date: _____

Charlotte Behavioral Health Care
AUTHORIZATION FOR REQUEST OR RELEASE OF INFORMATION
For Insurance Purposes

CHARLOTTE CBHC Behavioral Health Care

First Name _____ Last Name _____

DOB _____ SS# _____

Charlotte Behavioral Health Care, Inc. is requesting that the patient provide consent to release confidential information to the designated insurance carrier(s) for the purpose of receiving payment.

If you have insurance, we will submit signed claim forms to your insurance company; however, you will be responsible for the co-pay or adjusted fee prior to receiving services at each visit. We are not participating providers with all insurance carriers so this may affect what you will be asked to pay.

MEDICARE: PATIENT INFORMATION

Under federal law governing Charlotte Behavioral Health Care when accepting Medicare assignment for services rendered, **we are required to collect the co-payment amount stated by Medicare** on your explanation of benefits.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of medical benefits to the undersigned physician or supplier for services described as Charlotte Behavioral Health Care, Inc. I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits (Medicare) or insurance benefits, either to myself or to the party who accepts assignment (CBHC).

Please have the front office staff make a copy of your insurance card.

MEDICAID RELEASE OF INFORMATION

I certify that I am a recipient of the Medicaid Program Title XIX and request that payment and authorized benefits be made on my behalf. I authorize CBHC and CBHC insurance carrier to make available to the Florida Division of Children and Families any requested information concerning medical insurance and financial records relating to my medical care. I hereby certify all CBHC insurance payments shall be assigned to CBHC for services provided.

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services rendered unless other arrangements, payment plans, have been made in advance with our office billing staff.
I certify that the information provided for the sliding fee scale is accurate and complete to the best of my knowledge and in the event of a change in income, family size, or insurance coverage, I will notify CBHC.

Patient/SignatorySignature _____ Date _____

Staff/Witness Signature _____ Date _____

Name: _____ Case #: _____

Charlotte Behavioral Health Care
CONSENT FOR TREATMENT

I, the undersigned, a patient in Charlotte Behavioral Health Care, Inc.or I, the undersigned, a (parent of minor) (guardian of) (guardian advocate of)_____(Patient)

a patient in Charlotte Behavioral Health Care, Inc., and the subject of this consent, hereby authorizes the professional staff of the above-stated facility to administer treatment. I have been informed of the nature and purpose of treatment, common side effects thereof, alternative treatment modalities and approximate length of care; and that consent can be revoked at any time.

Confidentiality: **Charlotte Behavioral Health Care, Inc. is funded, in part, through contracts with the Florida Department of Children and Families. That agency requires access, with safeguards, to patients' social security numbers. I further understand that state and federal statutes protect confidentiality of my status as a patient of the Charlotte Behavioral Health Care, Inc. and that information will not be released without my written authorization or a Court Order. I understand that, as required by state and federal statutes, incidents of child or elder abuse will be reported to appropriate officials. Also, confidentiality may be breached when it is determined that a person's life is at risk because of threatening or dangerous behavior. Information can be released if the person is deemed to be a threat to self or others.**

Charlotte Behavioral Healthcare, Inc. chooses to communicate using text messaging, e-mail, and videoconferencing. Charlotte Behavioral Health Care uses video surveillance on all campuses including but not limited to inpatient units. I acknowledge that instructions for use of the electronic communication services have been more fully described in the Guide to Services. I understand and accept the risks outlined in the Guide to Services. I acknowledge and understand that it is possible that communications may have the potential to not be encrypted. I agree to allow Charlotte Behavioral Healthcare, Inc. staff to electronically communicate information regarding my care using these services with a full understanding of the risk.

Medicated Assisted (MAT) Services
I have been informed that it is recommended that I receive Medicated Assisted Treatment (MAT) Services.

I have been informed of CBHC's registry procedures. I understand that prior to any MAT Service the National Registry will be checked before prescribing any controlled substances.

I understand that I shall always report to the same provider unless prior approval is obtained from the original provider to transfer services to another provider.

***Patient**

_____ _____ _____
Patient Name Date Time

Representative/Legal Guardian

_____ _____ _____
Name Date Time

Signature of Person Recording Consent for Treatment

_____ _____ _____
Staff Name Date Time

*The patient shall always be asked to sign this consent form. In addition, a parent, guardian or guardian advocate may be asked to give consent.

Name _____ Case # _____

Type: Patient Assessment Medicaid # _____Date _____

CHARLOTTE CBHC Behavioral Health Care

CHARLOTTE BEHAVIORAL HEALTH CARE, INC.
1700 Education Avenue, Punta Gorda, Florida 33950

CONSENT FOR REPORTING COMMUNICABLE DISEASES

If, during the course of my treatment at Charlotte Behavioral Health Care, Inc., it is discovered that I have contracted a communicable disease,

I, _____(patient name), give my permission to inform the County Health Department in accordance with Florida Statute, Chapter 381, Public Health: General Provisions and Chapter 384, Sexually Transmitted Diseases.

This permission is limited for the duration of my treatment at Charlotte Behavioral Health Care.

_____ _____
Signature of Patient* Date

_____ _____
Signature of Representative/Legal Guardian Date

_____ _____
Signature of Person Recording Consent for Treatment Date

*The patient shall always be asked to sign this consent form. In addition, a parent, guardian or guardian advocate may be asked to give consent.

Name: _____ Case #: _____

Charlotte Behavioral Health Care, Inc.
INFORMED CONSENT FOR TELEHEALTH SERVICES

I understand that telehealth is the use of electronic information and communication technologies by a health care provider used to deliver services to an individual when he/she is located at a different location or site than I am.

I understand that the telehealth visit will be done through a two-way video link-up. The health care provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the health care provider.

I understand that the laws that protect privacy and the confidentiality of medical information including (HIPAA) also apply to telehealth.

I acknowledge and understand that it is possible that communications may have the potential at some point to not be encrypted. I agree to allow Charlotte Behavioral Health Care, Inc. staff to electronically communicate information regarding my care using these services with a full understanding of the risk. I acknowledge that either I or Charlotte Behavioral Health Care, Inc., may, at any time, withdraw the option of communicating electronically through the services upon providing written notice.

I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit at the time of the telehealth service.

I understand that I am responsible to have a private setting for my telehealth sessions and to disclose if anyone else is in the room or listening in on the telehealth session. I agree to provide written releases as needed.

I understand that if the treating professional determines that telehealth is not appropriate, he/she will work with me to arrange other services.

I understand that I must dress appropriately (as I would if coming to CBHC campus) and refrain from inappropriate behavior during the telehealth sessions.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

I understand that by signing this form that I am consenting to receive health care services via telehealth.

Patient Signature:

_____ _____ _____
Name Date Time

Parent/Guardian Signature:

_____ _____ _____
Name Date Time

Name: _____ Case #: _____

Type: Patient Assessment Medicaid #: _____ Date: _____

Charlotte Behavioral Health Care
GUIDE TO SERVICES
(This page is to be retained in the patient's chart)

I acknowledge that I have received, or reviewed with staff, a copy of the most recent CBHC Guide to Services, which includes the following information. I acknowledge that I may request a new copy of this publication at any time.

- Contact Information, Hours of Operation, Access to Services After-Hours
- Mission Statement and Co-Occurring Philosophy
- Description of our Services and Activities
- What to expect in treatment including:
  - Confidentiality Policy
  - Cancellation Policy
  - Identification of the person responsible for service coordination
  - The Assessment Process
  - The Individualized Treatment Plan
  - Rules for participation in Treatment
  - Transition criteria and procedures
- Your Responsibilities while receiving services, including:
  - Financial obligations and fees for service
  - Smoking policy
  - Safety policies, including weapons and legal or illegal drugs
- How to provide input about quality of care, achievement of outcomes, and satisfaction
- Post-discharge surveys
- How to file a Grievance (complaint)
- Your Rights while receiving services
- Notice of Privacy Practices
- Advance Directives
- Code of Ethics
- Building maps, including emergency exits, fire suppression equipment, and first aid kits

☐ Although the patient was offered the hard copy of the Guide to Services, they refused. This witnessing staff member verbally explained the contents of the Guide to Services and informed the patient they can request a copy of the publication at any time.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (when applicable) Date

_____ _____
Witness Signature (Staff Name) Date

Name _____ Case # _____

Type: Patient Assessment Medicaid # _____Date _____

Charlotte Behavioral Health Care
SUBSTANCE ABUSE CONSENT FOR URINALYSIS

I, the undersigned, a patient in **Charlotte Behavioral Health Care, Inc.**,

or

I, the undersigned, a (parent of minor) (guardian of) (guardian advocate of)

_____ (patient name),

a patient in Charlotte Behavioral Health Care, Inc., consent to routinely and randomly requested urinalysis for substance screening. I accept full responsibility for payment of fees for urinalysis screening (outpatient only), and I understand and acknowledge that refusal to submit to a request for urinalysis by the clinical staff and/or non-payment of fees for urinalysis screening shall be grounds for discharge from treatment.

I understand that if I am on probation, parole, or have pending charges that positive urinalysis results of drugs and/or alcohol shall be reported to the Court and/or its supervising officers as specified in my signed and dated **Release of Information of Charlotte Behavioral Health Care, Inc.** The results of the urinalysis will be used by Charlotte Behavioral Health Care, Inc. to monitor alcohol and drug use and as part of the treatment process.

_____ _____
Signature of Patient* Birth Date

_____ _____
Signature of Representative/ Legal Guardian Date

_____ _____
Signature of Person Recording Consent for Treatment Date

*The patient shall always be asked to sign this consent form. In addition, a parent, guardian or guardian advocate may be asked to give consent.

Charlotte Behavioral Health Care, Inc.
AUTHORIZATION TO REQUEST RELEASE OF INFORMATION TO PCP

CHARLOTTE CBHC Behavioral Health Care

First Name _____ MI _____ Last Name _____ DOB _____ SSN _____

I authorize **CHARLOTTE BEHAVIORAL HEALTH CARE, INC., 1700 Education Avenue, Punta Gorda, FL 33950** or any of its subsidiaries or affiliates and the clinician(s) performing services on behalf of CBHC in connection with my treatment to:

☐ **Disclose information to:** ☐ **Obtain information from:** *(If information is to be shared, check both boxes.)*

Name of Physician: _____

Physician Address: _____
Street City State ZIP

Please check one of the following boxes regarding the Primary Care Physician (PCP):
☐ CBHC may notify my PCP of treatment recommendations.
☐ Information may be released to PCP upon request from PCP.

Please indicate with check mark what we are requesting:
☐ Lab Reports or Diagnostic Tests (ECG, EKG) ☐ Progress Reports (Ind. Therapy) ☐ Medications (only)

Please indicate with check mark what is to be released:
☐ Comp Assessment SA/MH Adult/Child ☐ Psychiatric Evaluation and/or Med Service Notes
☐ Crisis Stabilization Unit/ Recovery Unit Admissions (if applicable)

☐ Other _____

This information for which I am authorizing disclosure will be used for the following purpose:
☐ To permit continuity of care

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization I must do so in writing and present to the Health Information Management Department. I understand that the revocation will not apply to the information that has already been released in response to this authorization.

I understand that this form may be used to release information related to mental health treatment, substance abuse treatment and may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information regarding Hepatitis A, B, C.

Signature of Patient or Legal Representative:

Patient Name _____ Date _____

This authorization will expire upon termination (discharge) of treatment with all providers of CBHC. I understand authorizing the use or disclosure of the information identified is voluntary. I need not sign this form to ensure healthcare treatment.

If signed by legal representative, relationship to patient: _____

Paper documentation establishing relationship is provided: ☐ Yes ☐ No _____

Witness Signature:

_____ _____

Witness Name Date

CBHC Medical Records Phone: 941-639-8300, ext. 2316

CBHC Medical Records Fax: 941-575-1865

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise prohibited by 42 CFR part 2.