Instructions:
1. Download form to your device.
2. Complete electronically.
3. Email to **intake@cbhcfl.org**

Registration Information

Basic Demographics

First Name: _____ Middle Name: _____ Last Name: _____ Suffix: _____

SSN: _____ DOB: _____ Gender: ☐ Male ☐ Female

Alias (maiden name, name change, etc.) _____

Marital Status:
☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

Primary Language:
☐ English ☐ Spanish ☐ Creole ☐ Russian ☐ Sign Language ☐ Other: _____

Ethnicity:
☐ Cuban ☐ Mexican ☐ Other Hispanic ☐ Puerto Rican ☐ Haitian ☐ N/A ☐ Mexican American ☐ Spanish/Latino

Race:
☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black ☐ Multi-Racial ☐ Native Hawaiian or Other Pacific Islander
☐ Other ☐ White

Accommodations Requested:
☐ Interpreter: Language/Dialect _____
☐ Reading Assistance ☐ Sign Language ☐ Large Print Materials ☐ TTY or Voice Relay ☐ CART ☐ Pocket Talker
☐ Assistance Filling Out Forms

Please indicate any disabilities/medical conditions:
☐ Developmental Disability ☐ Physical Disability ☐ Non-ambulatory ☐ Visually Impaired ☐ Hearing Impaired

Patient Information

Address: _____ City: _____ State: _____ Zip Code: _____

County of Residence: _____ Cell Phone Number: _____

Home Phone Number: _____ Work Phone Number: _____

Email Address: _____

CHARLOTTE CBHC Behavioral Health Care

Registration Information

Emergency Contact

Name: _____ Relationship: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or Parent Information

Name: _____ Relationship: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Child lives with: ☐ Mom ☐ Dad ☐ Both ☐ Other: _____

Are parents divorced/separated? ☐ Yes ☐ No ☐ N/A **If yes, parenting plan/divorce agreement must be attached.**

Additional Information

Employment Status
☐ Active Military ☐ Disabled ☐ Employed Full Time ☐ Employed Part Time ☐ Full Time Student ☐ Homemaker
☐ Leave of Absence ☐ Part Time Student ☐ Retired ☐ Unemployed ☐ Unknown

Educational Status
☐ Alt Education (HS Degree) ☐ Continuing Education ☐ Currently – Regular Education
☐ Currently – Special Education ☐ Not Currently Enrolled ☐ Vocational Training

Highest Education
☐ No School ☐ Nursery/Pre School/ Head Start ☐ Kindergarten ☐ Grade 1 ☐ Grade 2 ☐ Grade 3 ☐ Grade 4
☐ Grade 5 ☐ Grade 6 ☐ Grade 7 ☐ Grade 8 ☐ Grade 9 ☐ Grade 10 ☐ Grade 11 ☐ Grade 12
☐ HS Diploma/GED ☐ Vocational School ☐ Special School ☐ College Freshman ☐ College Sophomore
☐ College Junior ☐ College Senior ☐ Associate Degree ☐ Bachelor Degree ☐ Master Degree
☐ Professional Degree ☐ Doctorate Degree

Residential Status
☐ Independent Living – Alone ☐ Independent Living – with Relatives ☐ Independent Living – with Non-relatives
☐ Dependent Living – with Relatives ☐ Dependent Living – with Non-Relatives ☐ Assisted Living Facility
☐ Foster Care/Home ☐ Adult Residential (Group Home) ☐ Homeless ☐ State Mental Health Treatment Facility
☐ Nursing Home ☐ Supported Housing ☐ Correctional Facility ☐ DJJ Facility ☐ Crisis Residence
☐ Children's Residential Treatment Facility ☐ Limited Mental Health Licensed ALF ☐ Other Residential Status
☐ Not Available/Unknown

Registration Information

Legal Status

☐ Minor with Guardian ☐ Adult with Guardian Person & Property ☐ Adult with Guardian Property
☐ Adult with Guardian Person ☐ Adult with Guardian Advocate ☐ Adult

Have your ever or are you currently serving in the military? ☐ Yes ☐ No

Primary Care Provider

Name: _____ Phone: _____

Address: _____

_____ _____
Signature of Person Completing the Form Date

CHARLOTTE CBHC Behavioral Health Care

Financial Attestation

Patient Name: _____ DOB: _____

SC ID: _____ Date: _____

Thank you for choosing Charlotte Behavioral Health Care, Inc. We ask that you read and certify this form to acknowledge your understanding of our patient financial policies:

Commercial Insurance Carriers: We bill most insurance carriers for you if proper information is provided to us. Any outstanding balances, co-payments, and deductibles are your responsibility. If an insurance carrier has not paid within 90 days of billing, you may be billed. If payment is received from the insurance carrier at a later date, you will be given a refund, as appropriate.

Medicare: Our office is a Medicare Part B participating provider and we will bill Medicare Part B for you for outpatient services. (We are not a Medicare Part A provider.) Any co-insurance and non-covered service will be due as service is rendered.

Medicaid: Our office is a Medicaid participating provider and we will bill Medicaid for you. Standard Medicaid does not cover a bed day at our crisis unit, detox, or other residential settings and you will be billed as self-pay for those services.

Our office accepts the following payment methods: Cash, Personal Check, Money Order, and Credit Card. For returned checks, we assess a $25 charge to your account.

Many of our services qualify to be billed based on a sliding fee scale if there is **no insurance coverage**. If you would like to see if you qualify for the sliding fee scale, please be sure to ENTER you **TOTAL NUMBER IN HOUSEHOLD** and **HOUSEHOLD ANNUAL INCOME**. If not provided, you may be charged full fee. Sliding fee scale discounts are reviewed annually, or as needed due to a change in circumstances. Financial Counselors are available to meet with you during regular business hours or you may call 941-639-8300.

Please know a nominal co-payment for the following services may be assessed based on your qualification for our sliding fee scale:

1. Outpatient Treatment Services - $3 per day
2. Residential Treatment Services - $2 per day

Total Number in Household: _____ Household Annual Income: _____

Payment is expected at the time of service.

I authorize the release of any medical information and medical record necessary to process this claim. I also request payment of government benefits (Medicare), State benefits (Medicaid), or Third Party insurance benefits, to the party who accepts assignment (CBHC).

☐ I accept ☐ I Decline

I have read and agree with the above terms, and:

CHARLOTTE CBHC Behavioral Health Care

Financial Attestation

☐ 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.

☐ Decline to provide information on my household income and/or household size. I understand this information is needed for the uniform schedule of discounts and by not providing this information; I am unable to apply for uniform discounts, if applicable.

Office Staff Only

The individual ☐ declines or ☐ is unable to provide financial/household information.

Explain:

_____ _____
Signature of Patient Date

_____ _____
Signature of Representative/Legal Guardian Date

_____ _____
Signature of Staff Date

CHARLOTTE CBHC Behavioral Health Care

Consent for Treatment

Patient Name: _____ SC ID: _____ Date: _____

I, the undersigned, a patient at CBHC or I, the undersigned, a (parent of minor), (guardian of), (guardian advocate of) _____ (patient name) a patient at CBHC, 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*: CBHC is funded, in part, through contracts with the Florida Department of Children and Families (DCF). 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 CBHC 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 or neglect 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.**

CBHC chooses to communicate using text messaging, e-mail, and videoconferencing. 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 CBHC staff to electronically communicate information regarding my care using these services with a full understanding of the risk.

_____ _____
Signature of Patient* Date

_____ _____
Signature of Representative/Legal Guardian Date

_____ _____
Signature of Staff 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 CBHC Behavioral Health Care

Informed Consent for Telehealth Services

Patient Name: _____ SC ID: _____ Date: _____

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 CBHC staff to electronically communicate information regarding my care using these services with a full understanding of the risk. I acknowledge that either I or CBHC may, at any time, withdraw the option of communicating electronically through the services upon providing written notice.

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

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 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.

_____ _____

Signature of Patient* Date

_____ _____

Signature of Representative/Legal Guardian 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
CBHC
Behavioral Health Care

Acknowledgement of Receipt of Guide to Services
(This document is to be retained in the patient record)

Patient Name: _____ Patient ID: _____ Date: _____

I acknowledge that I have received, or reviewed with staff, a copy of the most recent CBHC Guide to Services, which includes the information listed below. 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 services and activities
- What to expect in treatment; including:
  - Confidentiality Policy
  - Cancellation Policy
  - Identification of the person responsible for service coordination
  - Assessment Process
  - Treatment Planning
  - Rules for participation in treatment
  - Transition criteria and procedures
- My responsibilities while receiving services; including:
  - Financial obligations and fees for service
  - Smoking policy
  - Safety policies, including weapons and legal or illegal drugs
  - Policies on seclusion and restraint
  - Restrictions that may be placed on you, actions that may lead to the loss of privileges or rights, and how to regain those rights
- How to provide input about quality of care, achievement of outcomes, and satisfaction
- Post-discharge surveys
- Grievance (complaint) process
- Your rights while receiving services
- Notice of Privacy Practices
- Advanced Directives
- Code of Ethics
- Building maps, including emergency exits, fire suppression equipment, and first aid kits.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/Guardian Advocate Signature Date

_____ _____
Witness Signature Date

Charlotte Behavioral Health Care

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 the specimen will be sent to an outside laboratory for further testing if the urinalysis results are positive for drugs and/or alcohol, if necessary.

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 CBHC Behavioral Health Care

Authorization to Obtain/Disclose Protected Health Information
Release of Information (ROI)

Patient Name: _____ SC ID: _____

DOB: _____ Effective Date: _____

General

This release not only covers the provision and receipt of all records maintained by Charlotte Behavioral Health Care, Inc. (CBHC), but also authorizes any member of the staff, employee of, or entity contracting with CBHC to discuss the case, treatment and records with the person authorized to receive information either in private conversations, depositions, or court testimony. Substance Use Disorder (SUD) records are protected under the Federal regulations governing Confidentiality and SUD Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any information disclosed is taken from the records of which the confidentiality is protected by State (394.459, 397.053, 381.609), (455 and 90) and/or Federal Law (42 CFR, Part 2) (45 CFR 160-164). 42 CFR, Part 2 prohibits CBHC from making any further disclosure without specific written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a SUD (HIPAA, 42 CRF Part 2, and 45 CFR parts 160 & 164) and cannot be disclosed without my written consent unless otherwise provided.

Release To/Release From

☐ Organization/Provider ☐ Individual Type: ☐ Release To ☐ Obtain From

Organization/Individual Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of Disclosure

☐ Process insurance/third party claims (Substance Use Remittance Only)
☐ Care Coordination: to permit continuity of care, keep EAP/Referral Source Informed
☐ HIE (Health Information Exchange)
☐ Other (please specify: i.e., legal reasons, to maintain family involvement in treatment, etc.):

_____

Expiration

If nothing is marked, one (1) year from date signed.

☐ One time disclosure ☐ 6 months ☐ End of Agency Treatment

Start Date: _____ End Date: _____

CHARLOTTE CBHC Behavioral Health Care

Authorization to Obtain/Disclose Protected Health Information
Release of Information (ROI)

Information to be Used or Disclosed

ROI Type: ☐ General ☐ Mental Health ☐ Substance Use Disorder

☐ Attendance Records ☐ Case Management Assessment Adult/Child ☐ Crisis Stabilization Unit
☐ Comprehensive Assessment SUD/MH Adult/Child ☐ Discharge Summary(ies) ☐ Group Notes
☐ Lab Reports, Diagnostic Test, etc. ☐ Progress Notes ☐ Residential and/or Detoxification Services
☐ Psychiatric Evaluation & Medication Management Services ☐ SUD records with no restrictions
☐ SUD records with limitations (only records indicated on this release) ☐ UDS and Lab Results
☐ Other (specify below)

Records Start Date: _____ Records End Date: _____

Restrictions (please specify below)

Terms

- Under state and federal confidentiality provisions only the information specified can be released.
- CBHC cannot ensure the recipient will maintain the confidentiality of the Mental Health and/or Substance Use Disorder (SUD) information authorized and released. If the person or organization obtaining this information is not a health care provider, health plan, or covered under the federal privacy regulations, the information may no longer be protected by federal privacy laws including 42 C.F.R. Part 2 and it could be re-disclosed.
- This authorization will be honored unless revoked in writing. Revocation may be made at any time except to the extent action has already been taken.
- Persons or organizations may not re-disclose substance use treatment information.
- This authorization will expire in one (1) year from the date of signature, unless otherwise specified in the expiration section above.
- This authorization is voluntary. I have been given the chance to ask questions and receive answers pertaining to this document.
- A list of entities to which my information has been released can be provided by CBHC.

By checking these boxes, I agree that I have read, understand and agree to these terms.
☐ Notice to Patient: Signing this form is voluntary and I understand I am under no obligation and my refusal will not affect my ability to obtain treatment.

☐ Access to my Record: I understand I can request a copy of my record. The request will be reviewed and approved by my provider. I understand I can review my records with my provider by making an appointment. The request can take 30 days to complete and charges may apply.

CHARLOTTE
CBHC
Behavioral Health Care

Authorization to Obtain/Disclose Protected Health Information
Release of Information (ROI)

Other

Copy given to Patient ☐ Yes ☐ Declined a copy Staff: _____

ID verified by: ☐ Driver's License ☐ Other Picture ID ☐ Known to Agency

Additional Information

Please note – The records released may contain alcohol and drug use information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Substance Use

☐ I authorize the release of information relating to referral and/or treatment for alcohol and substance use.

☐ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and substance use.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

☐ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

_____ _____

Signature of Patient Date

_____ _____

Signature of Representative/Legal Guardian Date

_____ _____

Signature of Staff/Witness Date

CHARLOTTE CBHC Behavioral Health Care

Authorization to Request or Release Protected Health Information – State Reporting
(This document is to be retained in the patient record)

Patient Name: _____ Date: _____

Patient ID: _____ SSN: _____

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 a patient's diagnosis, date of birth, income, education, gender, race, ethnicity, county of residence, and social security number.

This form will authorize CHARLOTTE BEHAVIORAL HEALTH CARE, INC. to release this information.

Information to be released to: Florida Department of Children and Families, Tallahassee, FL
Information to be released: Enrollment and Outcomes
State interim substance abuse report (SISAR)
Children's Functional Assessment Rating Scale (CFARs)

Specify the purpose for the release: To provide the State of Florida with research data to measure quality and outcome of services provided by Charlotte Behavioral Health Care, Inc.

The information is used to monitor compliance contract payments with Florida Department of Children and Families.

Specify date, condition or event upon which this authorization will expire: One (1) year from date of signature, unless revoked by the patient.

One Year from Dated Signature: _____
Printed Name: _____
Primary Phone: _____ **Secondary Phone:** _____

I understand that this authorization for release of information may be revoked at any time upon notification by me or the signatory, but that revocation has no effect on previous action taken in good faith.

NOTICE OF PROHIBITION ON REDISCLOSURE: Title 42 CFR Part 2, Florida Statutes 294.459, 296.112, 397.053, 381.609, 455.2416, 90.503, 90.242 and Florida Administrative Code 10E-5.038 protect the confidentiality of this information and prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2.

I certify that this authorization is being made voluntarily and without coercion.

_____ _____
Patient/Signatory Signature Date

_____ _____
Staff/Witness Signature Date

Charlotte Behavioral Health Care, Inc. is funded, in part, through contracts with the Florida Department of Children and Families.

Acknowledgement of Receipt of Patient Rights

(Patient will receive a copy of this document and a copy will be maintained in the patient record)

Patient Name: _____ Patient ID: _____ Date: _____

Charlotte Behavioral Health Care, Inc. (CBHC) is committed to protecting and promoting the rights of our patients, including the following areas:

Rights While Receiving Mental Health Services

Specific to Chapter 394, Florida Mental Health Act, the following rights are guaranteed to patients under Florida law. These rights will be fully explained upon admission to services.

1. **Right to Individual Dignity** – It is the policy of this state that the individual dignity of the patient shall be respected at all times and upon all occasions, including any occasion when the patient is taken into custody, held, or transported. Procedures, facilities, vehicles, and restraining devices utilized for criminals or those accused of crime shall not be used in connection with persons who have a mental illness, except for the protection of the patient or others. Persons who have a mental illness but who are not charged with a criminal offense shall not be detained or incarcerated in the jails of this state. A person who is receiving treatment for mental illness shall not be deprived of any constitutional rights. However, if such a person is adjudicated incapacitated, his or her rights may be limited to the same extent the rights of any incapacitated person are limited by law.

2. **Right to Treatment**
    a. A person shall not be denied treatment for mental illness and services shall not be delayed at a receiving or treatment facility because of inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services to persons able to pay for services, including insurance or third-party payments, shall be made by facilities providing services pursuant to this part.

    b. It is further the policy of the state that the least restrictive appropriate available treatment be utilized based on the individual needs and best interests of the patient and consistent with optimum improvement of the patient's condition.

    c. Each person who remains at a receiving or treatment facility for more than 12 hours shall be given a physical examination by a health practitioner authorized by law to give such examinations, within 24 hours after arrival at such facility.

    d. Every patient in a facility shall be afforded the opportunity to participate in activities designed to enhance self-image and the beneficial effects of other treatments, as determined by the facility.

    e. Not more than five (5) days after admission to a facility, each patient shall have and receive an individualized treatment plan in writing which the patient has had an opportunity to assist in preparing and to review prior to its implementation. The plan shall include a space for the patient's comments.

CHARLOTTE CBHC Behavioral Health Care

Acknowledgement of Receipt of Patient Rights

(Patient will receive a copy of this document and a copy will be maintained in the patient record)

3. **Right to Express and Informed Patient Consent**
   a. 1. Each patient entering treatment shall be asked to give express and informed consent for admission and treatment. If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment shall be sought instead from the patient's guardian or guardian advocate. If the patient is a minor, express and informed consent for admission or treatment shall also be requested from the patient's guardian. Express and informed consent for admission or treatment of patient under 18 years of age shall be required from the patient's guardian, unless the minor is seeking outpatient crisis intervention services under s. 394.4784. Express and informed consent for admission or treatment given by a patient who is under 18 years of age shall not be a condition of admission when the patient's guardian gives express and informed consent for the patient's admission pursuant to s. 394.463 or s. 394-467.

   2. Before giving express and informed consent, the following information shall be provided and explained in plain language to the patient, or to the patient's guardian if the patient is 18 years of age or older and has been adjudicated incapacitated, or to the patient's guardian advocate if the patient has been found to be incompetent to consent to treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects thereof; the specific dosage range for the medication, when applicable; alternative treatment modalities; the approximate length of care; the potential effects of stopping treatment; how treatment will be monitored; and that any consent given for treatment may be revoked orally or in writing before or during the treatment period by the patient or by a person who is legally authorized to make health care decisions on behalf of the patient.

   b. In the case of medical procedures requiring the use of a general anesthetic or electroconvulsive treatment, and prior to performing the procedure, express and informed consent shall be obtained from the patient if the patient is legally competent, from the guardian of a minor patient, from the guardian of a patient who has been adjudicated incapacitated, or from the guardian advocate of the patient if the guardian advocate has been given express court authority to consent to medical procedures or electroconvulsive treatment as provided under s. 394.4598.

   c. When the department is the legal guardian of a patient, or is the custodian of a patient whose physician is unwilling to perform a medical procedure, including an electroconvulsive treatment, based solely on the patient's consent and whose guardian or guardian advocate is unknown or unlocatable, the court shall hold a hearing to determine the medical necessity of the medical procedure. The patient shall be physically present, unless the patient's medical condition precludes such presence, represented by counsel, and provided the right and opportunity to be confronted with, and to cross-examine, all witnesses alleging the medical necessity of such procedure. In such proceedings, the burden of proof by clear and convincing evidence shall be on the party alleging the medical necessity of the procedure.

d. The administrator of a receiving or treatment facility may, upon the recommendation of the patient's attending physician, authorize emergency medical treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient, and permission of the patient or the patient's guardian or guardian advocate cannot be obtained.

4. **Quality of Treatment**
   a. Each patient shall receive services, including, for a patient placed under s. 394.4655, those services included in the court order which are suited to his or her needs, and which shall be administered skillfully, safely, and humanely with full respect for the patient's dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational, and rehabilitative services as his or her condition requires in order to live successfully in the community. In order to achieve this goal, the department is directed to coordinate its mental health programs with all other programs of the department and other state agencies.

   b. Facilities shall develop and maintain, in a form accessible to and readily understandable by patients and consistent with rules adopted by the department, the following:
      i. Criteria, procedures, and required staff training for any use of close or elevated levels of supervision, of restraint, seclusion, or isolation, or of emergency treatment orders, and for the use of bodily control and physical management techniques.
      ii. Procedures for documenting, monitoring, and requiring clinical review of all uses of the procedures described in subparagraph 1. and for documenting and requiring review of any incidents resulting in injury to patients.
      iii. A system for investigating, tracking, managing, and responding to complaints by persons receiving services or individuals acting on their behalf.

   c. A facility may not use seclusion or restraint for punishment, to compensate for inadequate staffing, or for the convenience of staff. Facilities shall ensure that all staff are made aware of these restrictions on the use of seclusion and restraint and shall make and maintain records which demonstrate that this information has been conveyed to individual staff members.

5. **Communication, Abuse Reporting, and Visits**
   a. Each person receiving services in a facility providing mental health services under this part has the right to communicate freely and privately with persons outside the facility unless a qualified professional determines that such communication is likely to be harmful to the person or others in a manner directly related to the person's clinical well-being, the clinical well-being of other patients, or the general safety of staff. Each facility shall make available as soon as reasonably possible to persons receiving services a telephone that allows for free local calls and access to a long-distance service. A facility is not required to pay the costs of a patient's long-distance calls. The telephone shall be readily accessible to the patient and shall be placed so that the patient may use it to communicate privately and confidentially. The facility may establish reasonable rules for the use of this telephone, provided that the rules do not interfere with a patient's access to a telephone to report abuse pursuant to paragraph (f).

Acknowledgement of Receipt of Patient Rights

(Patient will receive a copy of this document and a copy will be maintained in the patient record)

b. Each patient admitted to a facility under the provisions of this part shall be allowed to receive, send, and mail sealed, unopened correspondence; and no patient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless a qualified professional determines that such correspondence is likely to be harmful to the patient or others in a manner directly related to the patient's clinical well-being, the clinical well-being of other patients, or the general safety of staff. If there is reason to believe that such correspondence contains items or substances which may be harmful to the patient or others, the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances.

c. Each facility must permit immediate access to any patient, subject to the patient's right to deny or withdraw consent at any time, by the patient's family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney, unless a qualified professional determines that such access would be detrimental to the patient in a manner directly related to the patient's clinical well-being, the clinical well-being of other patients, or the general safety of staff.

d. If a patient's right to communicate with outside persons; receive, send, or mail sealed, unopened correspondence; or receive visitors is restricted by the facility, written notice of such restriction and the reasons for the restriction shall be served on the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative; a qualified professional must document any restriction within 24 hours, and such restriction shall be recorded on the patient's clinical record with the reasons therefor. The restriction of a patient's right to communicate or to receive visitors shall be reviewed at least every 3 days. The right to communicate or receive visitors shall not be restricted as a means of punishment. Nothing in this paragraph shall be construed to limit the provisions of paragraph (e).

e. Each facility shall establish reasonable rules governing visitors, visiting hours, and the use of telephones by patients in the least restrictive possible manner. Patients shall have the right to contact and to receive communication from their attorneys at any reasonable time.

f. Each patient receiving mental health treatment in any facility shall have ready access to a telephone in order to report an alleged abuse. The facility staff shall orally and in writing inform each patient of the procedure for reporting abuse and shall make every reasonable effort to present the information in a language the patient understands. A written copy of that procedure, including the telephone number of the central abuse hotline and reporting forms, shall be posted in plain view.

g. The department shall adopt rules providing a procedure for reporting abuse. Facility staff shall be required, as a condition of employment, to become familiar with the requirements and procedures for the reporting of abuse.

6. **Care and Custody of Personal Effects of Patients** - A patient's right to the possession of his or her clothing and personal effects shall be respected. The facility may take temporary custody of such effects when required for medical and safety reasons. A patient's clothing and personal effects shall be inventoried upon their removal into temporary custody. Copies of this inventory shall be given to the patient and to the patient's guardian, guardian advocate, or representative

and shall be recorded in the patient's clinical record. This inventory may be amended upon the request of the patient or the patient's guardian, guardian advocate, or representative. The inventory and any amendments to it must be witnessed by two members of the facility staff and by the patient, if able. All of a patient's clothing and personal effects held by the facility shall be returned to the patient immediately upon the discharge or transfer of the patient from the facility, unless such return would be detrimental to the patient. If personal effects are not returned to the patient, the reason must be documented in the clinical record along with the disposition of the clothing and personal effects, which may be given instead to the patient's guardian, guardian advocate, or representative. As soon as practicable after an emergency transfer of a patient, the patient's clothing and personal effects shall be transferred to the patient's new location, together with a copy of the inventory and any amendments, unless an alternate plan is approved by the patient, if able, and by the patient's guardian, guardian advocate, or representative.

7. **Voting in Public Elections** - A patient who is eligible to vote according to the laws of the state has the right to vote in the primary and general elections. The department shall establish rules to enable patients to obtain voter registration forms, applications for vote-by-mail ballots, and vote-by-mail ballots.

8. **Habeas Corpus**

    a. At any time, and without notice, a person held in a receiving or treatment facility, or a relative, friend, guardian, guardian advocate, representative, or attorney, or the department, on behalf of such person, may petition for a writ of habeas corpus to question the cause and legality of such detention and request that the court order a return to the writ in accordance with chapter 79. Each patient held in a facility shall receive a written notice of the right to petition for a writ of habeas corpus.

    b. At any time, and without notice, a person who is a patient in a receiving or treatment facility, or a relative, friend, guardian, guardian advocate, representative, or attorney, or the department, on behalf of such person, may file a petition in the circuit court in the county where the patient is being held alleging that the patient is being unjustly denied a right or privilege granted herein or that a procedure authorized herein is being abused. Upon the filing of such a petition, the court shall have the authority to conduct a judicial inquiry and to issue any order needed to correct an abuse of the provisions of this part.

    c. The administrator of any receiving or treatment facility receiving a petition under this subsection shall file the petition with the clerk of the court on the next court working day.

    d. No fee shall be charged for the filing of a petition under this subsection.

9. **Violations** - The department shall report to the Agency for Health Care Administration any violation of the rights or privileges of patients, or of any procedures provided under this part, by any facility or professional licensed or regulated by the agency. The agency is authorized to impose any sanction authorized for violation of this part, based solely on the investigation and findings of the department.

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10. **Liability for Violations** - Any person who violates or abuses any rights or privileges of patients provided by this part is liable for damages as determined by law. Any person who acts in good faith in compliance with the provisions of this part is immune from civil or criminal liability for his or her actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility. However, this section does not relieve any person from liability if such person commits negligence.

11. **Right to Participate in Treatment and Discharge Planning** - The patient shall have the opportunity to participate in treatment and discharge planning and shall be notified in writing of his or her right, upon discharge from the facility, to seek treatment from the professional or agency of the patient's choice.

12. **Posting of Notice of Rights of Patients** - Each facility shall post a notice listing and describing, in the language and terminology that the persons to whom the notice is addressed can understand, the rights provided in this section. This notice shall include a statement that provisions of the federal Americans with Disabilities Act apply and the name and telephone number of a person to contact for further information. This notice shall be posted in a place readily accessible to patients and in a format easily seen by patients. This notice shall include the telephone numbers of the Florida local advocacy council and Advocacy Center for Persons with Disabilities, Inc.

Patient rights are shared with patients and their families in our "Guide to Services." Staff is also required to adhere to certain ethical standards and codes of conduct, as written in the CBHC Compliance Plan.

Patients will receive services regardless of the inability to pay or whether payment of services is Medicaid, Medicare, or CHIP.

Rights while Receiving Substance Use Services

Specific to 65D-30, individuals applying for and receiving services for substance use disorders are guaranteed the protection of fundamental human, civil, constitutional, and statutory rights, including those specified in subsections 397-501(1)-(10), F.S. [Reference 65D-30.0045(1)].

1. **Provisions** - Basic individual rights shall include [Reference 65D-30.0045(1)(a)1-10.]:
    a. Provisions for informing the individual, family member, or authorized guardian of their rights and responsibilities, assisting in the exercise of those rights, and an accessible grievance system for resolution of conflicts;

    b. Provisions assuring that a grievance may be filed for any reason with cause;

    c. The prominent posting of notices informing individuals of the grievance system;
        i. These are posted in main lobbies in outpatient buildings, in the adult and adolescent day rooms in the integrated crisis and addiction receiving facility, and in the day room at the 28-day residential treatment center.

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d. Access to grievance submission forms;
   i. Anyone can request a grievance form from any staff member and one will be provided. If assistance is required in completing the form, staff will provide assistance.

e. Education of staff in the importance of the grievance system and individual rights;

f. Specific levels of appeal with corresponding time frames for resolution;
   i. If the issue remains unresolved or the patient notifies CBHC of dissatisfaction with the written disposition, the COO will review the grievance, and discuss the issue with the individuals involved within three (3) business days of receipt of the unresolved grievance.

   ii. The disposition of a grievance may be appealed to the CEO. If appealed, the CEO or designee shall review the written grievance and the initial disposition and a final written response will be made within five (5) business days of the receipt of the appeal. The written response will be given or mailed to the patient within 24 hours of final disposition.

g. Timely receipt of a filed grievance;
   i. Once a grievance is submitted, the staff member who receives the form will scan the document to the Quality Management Department and provide the original copy to the program director/manager. The person most appropriate to handle the grievance will contact the patient (within 24 hours for inpatient and 72 hours for outpatient).

h. The logging and tracking of filed grievances until resolved or concluded by actions of the provider's governing board;
   i. The Quality Management department maintains a log of all grievances filed, including but not limited to the patient name, date of grievance, staff and/or departments involved types of complaint, date of response, and resolution.

i. Written notification of the decision to the appellant; and

j. Analysis of trends to identify opportunities for improvement.
   i. The Quality Management department will review all grievances as they are received. At minimum, on a quarterly basis, the Quality Management department will review and identify patters and trends related to particular providers or services or to identify other areas needing performance improvement. This information is reviewed and discussed in various committees (safety, clinical, executive, management, etc.) based on topic and published in the annual summary of grievances in the Annual Outcomes report. Grievances submitted against a specific employee are compiled annually and forwarded to that person's supervisor to be reviewed in the annual performance evaluation. The number of grievances filed will be documented, along with the outcome or explanation of those complaints and any supervision and/or performance improvement activities that were provided as a result.

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2. **Providing Information to Affected Parties** - Notification to all parties of these rights shall include affirmation of an organizational non-relationship policy that protects a party's right to file a grievance or express their opinion and invokes applicability of state and federal protections. Providers shall post the number of the abuse hotline, Disability Rights Florida, and the regional Office of Substance Abuse and Mental Health in a conspicuous place within each facility and provide a copy to each individual receiving services.

3. **Implementation of Individual Rights Requirements by Department of Corrections and Department Management Services.** – In lieu of the requirements of this subsection, the rights of individuals in substance abuse programs:
    a. Operated by the Department of Corrections shall be protected by the policies and procedures established by the Department of Corrections.
    b. Under contract with the Department of Management Services shall be protected by the terms of the contract.
        i. Individual Employment. Providers shall ensure that all work performed on behalf of the provider by an individual receiving services is voluntary, justified by the treatment plan, and that all wages, if any, are in accordance with applicable wage and disability laws and regulations.

Specific to Chapter 397.501, individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

1. **Right to Individual Dignity** - The dignity of the individual served must be respected at all times and upon all occasions, including any occasion when the individual is admitted, retained, or transported. Individuals served who are not accused of a crime or delinquent act may not be detained or incarcerated in jails, detention centers, or training schools of the state, except for purposes of protective custody in strict accordance with this chapter. An individual may not be deprived of any constitutional right.

2. **Right to Nondiscriminatory services**
    a. Service providers may not deny an individual access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, human immunodeficiency virus status, prior service departures against medical advice, disability, or number of relapse episodes. Service providers may not deny an individual who takes medication prescribed by a physician or an advanced practice registered nurse registered under s. 464.0123 access to substance abuse services solely on that basis. Service providers who receive state funds to provide substance abuse services may not, if space and sufficient state resources are available, deny access to services based solely on inability to pay.

    b. Each individual in treatment must be afforded the opportunity to participate in the formulation and periodic review of his or her individualized treatment or service plan to the extent of his or her ability to so participate.

    c. It is the policy of the state to use the least restrictive and most appropriate services available, based on the needs and the best interests of the individual and consistent with optimum care of the individual.

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d. Each individual must be afforded the opportunity to participate in activities designed to enhance self-image.

3. **Right to Quality Services**
   a. Each individual must be delivered services suited to his or her needs, administered skillfully, safely, humanely, with full respect for his or her dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

   b. These services must include the use of methods and techniques to control aggressive behavior that poses an immediate threat to the individual or to other persons. Such methods and techniques include the use of restraints, the use of seclusion, the use of time-out, and other behavior management techniques. When authorized, these methods and techniques may be applied only by persons who are employed by service providers and trained in the application and use of these methods and techniques. The department must specify by rule the methods that may be used and the techniques that may be applied by service providers to control aggressive behavior and must specify by rule the physical facility requirements for seclusion rooms, including dimensions, safety features, methods of observation, and contents.

4. **Right to Communication**
   a. Each individual has the right to communicate freely and privately with other persons within the limitations imposed by service provider policy.

   b. Because the delivery of services can only be effective in a substance abuse free environment, close supervision of each individual's communications and correspondence is necessary, particularly in the initial stages of treatment, and the service provider must therefore set reasonable rules for telephone, mail, and visitation rights, giving primary consideration to the well-being and safety of individuals, staff, and the community. It is the duty of the service provider to inform the individual and his or her family if the family is involved at the time of admission about the provider's rules relating to communications and correspondence.

5. **Right to Care and Custody of Personal Effects** - An individual has the right to possess clothing and other personal effects. The service provider may take temporary custody of the individual's personal effects only when required for medical or safety reasons, with the reason for taking custody and a list of the personal effects recorded in the individual's clinical record. A service provider shall return an individual's personal effects upon the individual's discharge, even if the discharge is against medical advice.

6. **Right to Education of Minors** - Each minor in a residential service component is guaranteed education and training appropriate to his or her needs. The service provider shall coordinate with local education agencies to ensure that education and training is provided to each minor in accordance with other applicable laws and regulations and that parental responsibilities related to such education and training are established within the provisions of such applicable laws and regulations. This chapter does not relieve any local education authority of its obligation under law to provide a free and appropriate education to every child.

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7. **Right to Confidentiality of Individual Records**

   a. The records of service providers which pertain to the identity, diagnosis, and prognosis of and service provision to any individual are confidential in accordance with this chapter and with applicable federal confidentiality regulations and are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such records may not be disclosed without the written consent of the individual to whom they pertain except that appropriate disclosure may be made without such consent:
      i. To medical personnel in a medical emergency.

      ii. To service provider personnel if such personnel need to know the information in order to carry out duties relating to the provision of services to an individual.

      iii. To the secretary of the department or the secretary's designee, for purposes of scientific research, in accordance with federal confidentiality regulations, but only upon agreement in writing that the individual's name and other identifying information will not be disclosed.

      iv. In the course of review of service provider records by persons who are performing an audit or evaluation on behalf of any federal, state, or local government agency, or third-party payor providing financial assistance or reimbursement to the service provider; however, reports produced as a result of such audit or evaluation may not disclose names or other identifying information and must be in accordance with federal confidentiality regulations.

      v. Upon court order based on application showing good cause for disclosure. In determining whether there is good cause for disclosure, the court shall examine whether the public interest and the need for disclosure outweigh the potential injury to the individual, to the service provider and the individual, and to the service provider itself.

   b. The restrictions on disclosure and use in this section do not apply to communications from provider personnel to law enforcement officers which:
      i. Are directly related to an individual's commission of a crime on the premises of the provider or against provider personnel or to a threat to commit such a crime; and
      ii. Are limited to the circumstances of the incident, including the status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

   c. The restrictions on disclosure and use in this section do not apply to the reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law. However, such restrictions continue to apply to the original substance abuse records maintained by the provider, including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

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d. Any answer to a request for a disclosure of individual records which is not permissible under this section or under the appropriate federal regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for substance abuse. The regulations do not restrict a disclosure that an identified individual is not and has never received services.

e. 1. Since a minor acting alone has the legal capacity to voluntarily apply for and obtain substance abuse treatment, any written consent for disclosure may be given only by the minor. This restriction includes, but is not limited to, any disclosure of identifying information to the parent, legal guardian, or custodian of a minor for the purpose of obtaining financial reimbursement.

2. When the consent of a parent, legal guardian, or custodian is required under this chapter in order for a minor to obtain substance abuse treatment, any written consent for disclosure must be given by both the minor and the parent, legal guardian, or custodian.

f. An order of a court of competent jurisdiction authorizing disclosure and use of confidential information is a unique kind of court order. Its only purpose is to authorize a disclosure or use of identifying information which would otherwise be prohibited by this section. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as, and accompany, an authorizing court order entered under this section.

g. An order authorizing the disclosure of an individual's records may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed alone or as part of a pending civil action or an active criminal investigation in which it appears that the individual's records are needed to provide evidence. An application must use a fictitious name, such as John Doe or Jane Doe, to refer to any individual and may not contain or otherwise disclose any identifying information unless the individual is the applicant or has given a written consent to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

h. 1. For applications filed alone or as part of a pending civil action, the individual and the person holding the records from whom disclosure is sought must be given adequate notice in a manner which will not disclose identifying information to other persons, and an opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order.

2. Applications filed as part of an active criminal investigation may, in the discretion of the court, be granted without notice. Although no express notice is required to the agents, owners, and employees of the treatment provider or to any individual whose records are to be disclosed, upon implementation of an order so granted, any of these persons must be afforded an opportunity to seek revocation or amendment of the order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the order.

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i. Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that identifying information is not disclosed to anyone other than a party to the proceeding, the individual, or the person holding the record, unless the individual requests an open hearing. The proceeding may include an examination by the judge of the records referred to in the application.

j. A court may authorize the disclosure and use of records for the purpose of conducting a criminal investigation or prosecution of an individual only if the court finds that all of the following criteria are met:
    i. The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury, including but not limited to homicide, sexual assault, sexual battery, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

    ii. There is reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

    iii. Other ways of obtaining the information are not available or would not be effective.

    iv. The potential injury to the individual, to the physician-individual relationship, and to the ability of the program to provide services to other individuals is outweighed by the public interest and the need for the disclosure.

8. **Right to Counsel** - Each individual must be informed that he or she has the right to be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment and that he or she, or if the individual is a minor his or her parent, legal guardian, or legal custodian, may apply immediately to the court to have an attorney appointed if he or she cannot afford one.

9. **Right to Habeas Corpus** - At any time, and without notice, an individual involuntarily retained by a provider, or the individual's parent, guardian, custodian, or attorney on behalf of the individual, may petition for a writ of habeas corpus to question the cause and legality of such retention and request that the court issue a writ for the individual's release.

10. **Liability and Immunity**

    a. Service provider personnel who violate or abuse any right or privilege of an individual under this chapter are liable for damages as determined by law.

    b. All persons acting in good faith, reasonably, and without negligence in connection with the preparation or execution of petitions, applications, certificates, or other documents or the apprehension, detention, discharge, examination, transportation, or treatment of a person under the provisions of this chapter shall be free from all liability, civil or criminal, by reason of such acts.

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_____	_____
Patient Signature	Date
_____	_____
Parent/Guardian/Guardian Advocate Signature	Date
_____	_____
Witness Signature	Date

CHARLOTTE CBHC Behavioral Health Care

Consent for Reporting Communicable Diseases

Patient Name: _____ SC ID: _____ Date: _____

If, during the course of my treatment at CBHC, 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 to the duration of my treatment at CBHC.

_____ _____
Signature of Patient* Date

_____ _____
Signature of Representative/Legal Guardian Date

_____ _____
Signature of Staff 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.

Clear Form

CHARLOTTE CBHC Behavioral Health Care

HIV/AIDS & HBV Information Sheet & Risk Assessment Form

Patient will receive a copy of this document and a copy will be maintained in the patient record

Patient Name: _____ SC ID: _____ Date: _____

Patient Information Sheet – HIV/AIDS

Facts about HIV infection and AIDS: Please read carefully. Your counselor will review this information with you line by line in order to answer any questions or to clarify any area that may not be clear. This form will be kept in your confidential patient record. If you would like a fact sheet or pamphlets, they are available free of charge. All of us are partners in the prevention of HIV infection and AIDS.

1. HIV stands for human immunodeficiency virus. It weakens a person's immune system by destroying important cells that fight diseases and infection. There is currently no effective cure for HIV, but with proper medical care, HIV can be controlled. Some groups of people in the US are more likely to get HIV than others because of many factors, including their sex partners and risk behaviors. If HIV is not treated, it can lead to AIDS (acquired immunodeficiency syndrome).

2. Some people have flu-like symptoms within 2 to 4 weeks after infection. These symptoms may last for a few days or several weeks. Possible symptoms include: fever, chills, rash, night sweats, muscle aches, sore throat fatigue, swollen lymph nodes, and mouth ulcers. Others may not experience symptoms.

3. HIV can be transmitted by sexual contact, sharing needles to inject drugs, mother to baby during pregnancy, birth, or breastfeeding.

4. HIV is not transmitted by air, water, saliva, sweat, tears, closed mouth kissing, insects, pets, sharing toilets, sharing food, or sharing drinks.

5. Protect yourself from HIV by following these guidelines:
    a. Get tested at least once or more often if you are at risk
    b. Use condoms the right way every time you have anal or vaginal sex
    c. Choose activities with little to no risk like oral sex
    d. Don't inject drugs, or if you do, don't share needles, syringes, or other drug injection equipment.
    e. If you are at risk for HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.
    f. If you think you've been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
    g. Get tested and treated for other STDs.

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6. Keep yourself healthy and protect others if you have HIV by following these guidelines:
    a. Find HIV care. It can keep you healthy and help reduce the risk of transmitting HIV to others.
    b. Take your HIV medications as prescribed.
    c. Stay in HIV care.
    d. Tell your sex or injection partners that you have HIV. Use condoms the right way every time you have sex, and talk to your partners about PrEP.
    e. Get tested and treated for other STDs.

7. People with HIV should take medicine to treat HIV as soon as possible to improve their own health and prevent transmitting HIV to other people. HIV medications can reduce the amount of HIV in the blood (also called viral load). HIV medication can make the viral load so low that a test can't detect it. This is called undetectable viral load. Having an undetectable viral load (or staying virally suppressed) is the best thing people with HIV can do to stay healthy. If their viral load stays undetectable, they have effectively no risk of transmitting HIV to their sex partner.

8. Further information is available on testing from your counselor and remember that medical assessment is the proper way to have your health assessed. We will be glad to help you in locating resources to accomplish this.

9. If you go get tested, your results are confidential; however, CBHC may be required to report the results to the local health department in accordance with state law.

Patient Information Sheet – HBV/Hepatitis B Virus

Facts about HBV: please read carefully. Your counselor will clarify any area that may not be clear. This form will be kept in your confidential patient record. There is free literature available if you want more information.

1. Hepatitis B virus (HBV) is a vaccine-preventable liver infection caused by the hepatitis B virus.

2. HBV is spread when blood, semen, or other body fluids from a person infected with the virus enters the body of someone who is not infected. This can happen through sexual contact; sharing needles, syringes, or other drug-injection equipment; contact with blood from or open sores of an infected person; exposures to needle sticks or sharp instruments; sharing certain items with an infected person that can break the skin or mucous membranes (e.g., razors, toothbrushes, and glucose monitoring equipment), potentially resulting in exposure to blood; or from mother to baby at birth. HBV can survive outside the body and remains infectious for at least 7 days.

3. Not all people newly infected with HBV have symptoms, but for those that do, symptoms can include fatigue, poor appetite, stomach pain, nausea, vomiting, clay colored stool, dark urine, joint pain, and jaundice (yellowing of the skin). If symptoms occur, they begin an average of 90 days (range 60-150 days) after exposure and typically last for several weeks, but can persist for up to 6 months. For many people HBV is a short-term illness. For others, it can become a long-term chronic infection that can lead to serious, even life-threatening health issues like cirrhosis or liver cancer.

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HIV/AIDS & HBV Information Sheet & Risk Assessment Form

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4. Risk of chronic infection is related to age at infection: about 90% of infants with hepatitis B go on to develop chronic infection, whereas only 2% - 6% of people who get hepatitis B as adults become chronically infected.

5. Three different serologic tests are needed to determine whether a patient has HBV, is immune as a result of prior infection, or is susceptible and in need of a vaccine.

6. The best way to prevent hepatitis B is to get vaccinated.

7. For individuals with acute infection, treatment is provided depending on symptoms. For people with chronic infection, several anti-viral medications are available; these patients require linkage to care with regular monitoring to prevent liver damage and/or hepatocellular carcinoma.

Further information is available from your counselor. We will be glad to provide further information regarding HBV.

HIV & HBV Risk Assessment

Please read each of the following questions and check your answer or fill in where indicated.

1. Have you ever used a needle to take drugs including steroids: Intravenously (IV) or intramuscularly (IM)? ☐ Yes ☐ No
2. Have you ever shared needles or works with anyone? ☐ Yes ☐ No
3. Did you ever forget what you did when you were high or drunk? ☐ Yes ☐ No
4. Have you ever been to jail or prison? ☐ Yes ☐ No
5. Did you ever engage in sex, willingly or unwillingly, while you were in jail or prison? ☐ Yes ☐ No
6. Have you ever engaged in sex for money or drugs? ☐ Yes ☐ No
7. Have you ever exchanged money for drugs or sex? ☐ Yes ☐ No
8. Have you had more than one sex partner in the past year? ☐ Yes ☐ No
9. Did you receive a blood transfusion or blood products between 1977-1990 ☐ Yes ☐ No
   If yes, in what year? _____
10. Have you ever had Herpes, Hepatitis B, Syphilis, Gonorrhea, Chlamydia or sores in the genital area? ☐ Yes ☐ No
11. Do you have any tattoos? ☐ Yes ☐ No

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HIV/AIDS & HBV Information Sheet & Risk Assessment Form

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12. Have you ever shared works or a needle or had sex with anyone that you now know is HIV positives, has AIDS, or has HBV? If yes, which? _____ ☐ Yes ☐ No

13. **For men only:** Have you ever had male to male sex? ☐ Yes ☐ No

14. Have you ever had a sexual partner that you would consider to be a risk for HIV and/or HBV? If yes, which? _____ ☐ Yes ☐ No

15. Have you ever had sex with anyone who would answer "yes" to any of the above questions? ☐ Yes ☐ No

16. Do you believe that you are at risk for HIV and/or HBV? ☐ Yes ☐ No

17. Have you ever shared personal care items (razors, toothbrushes, and nail clippers) with someone infected with HBV? ☐ Yes ☐ No

Communicable Disease Questionnaire

This brief questionnaire is a screening tool to help identify possible communicable diseases. **Please read each of the following questions and check your answers or fill in where indicated.**

Do you currently have or have you ever had:

Measles ☐ No ☐ Yes Date _____ Hepatitis ☐ No ☐ Yes Date _____

Mumps ☐ No ☐ Yes Date _____ HIV ☐ No ☐ Yes Date _____

Rubella ☐ No ☐ Yes Date _____ Tuberculosis ☐ No ☐ Yes Date _____

Chicken Pox ☐ No ☐ Yes Date _____ Flu ☐ No ☐ Yes Date _____

MRSA ☐ No ☐ Yes Date _____

Other: _____ Date _____

Are you now under the care of a physician or taking any medication for a communicable disease?
☐ No ☐ Yes If yes, please explain:

Have you had recent contact with someone with any of the above illnesses? ☐ No ☐ Yes
If yes, please explain:

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HIV/AIDS & HBV Information Sheet & Risk Assessment Form

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Have you ever been tested for tuberculosis? ☐ No ☐ Yes Date _____

If yes, did you have a chest x-ray? ☐ No ☐ Yes Date _____

Were you ever treated for positive TB test? ☐ No ☐ Yes Date _____

Please check Yes or No to ALL symptoms as they apply to you:

- Productive cough (3 weeks or more) ☐ No ☐ Yes
- Persistent weight loss without dieting ☐ No ☐ Yes
- Persistent low grade fever ☐ No ☐ Yes
- Night Sweats ☐ No ☐ Yes
- Loss of appetite ☐ No ☐ Yes
- Swollen glands, usually in the neck ☐ No ☐ Yes

- Recurrent kidney infections ☐ No ☐ Yes
- Shortness of breath ☐ No ☐ Yes
- Chest pain ☐ No ☐ Yes
- Have you traveled outside of the US within the last 30 days ☐ No ☐ Yes
  If yes, please explain:

If you have answered yes to any of the questions above you are considered at risk for any of these conditions. CBHC recommends testing for communicable diseases, sexually transmitted infections (STI), HIV/AIDS, or HBV. Please see below to either accept or decline referral for testing.

☐ I decline testing/referral at the County Health Department.

☐ I accept and am interested in testing and will use this as a referral to follow-up with my local health department:

- Charlotte County: 941-624-7200 1100 Loveland Blvd, Port Charlotte, FL 33980
- DeSoto County: 863-491-7580 1031 E Oak St, Arcadia, FL 34266
- Lee County: 239-332-9501 3920 Michigan Ave, Fort Myers, FL 33916
- Sarasota County: 941-861-2900 2200 Ringling Blvd, Sarasota, FL 34237

HIV testing completed: ☐ Yes ☐ No ☐ Declined If yes, date HIV test completed: _____

I have read the above information and discussed it with my counselor. I understand the activities and behaviors which could put me at risk for communicable diseases, STI, HIV/AIDS, or HBV infection. I have been advised that testing and counseling are available at a County Health Department (phone number and addresses above). I agree to discuss any questions I may have with my counselor. I acknowledge that I have received and reviewed a copy of the most recent CBHC HIV/HBV/Communicable Disease Pamphlet. I acknowledge that I may request a new copy of this publication at any time. I acknowledge information is available from my provider.

Instructions:
1. Download form to your device.
2. Complete electronically.
3. Email to **intake@cbhcfl.org**

/ Information Sheet & Risk Assessment Form

Patient will receive a copy of this document and a copy will be maintained in the patient record
****Staff Use Only****

After review of answers, what actions have been taken?

****Inpatient Use Only****

If fever of 100 degrees or high AND any of the following symptoms: cough, sore throat, headache, body aches, vomiting, diarrhea, fatigue, or chills, **PLEASE SEND TO THE HOSPITAL FOR MEDCIAL CLEARANCE.**

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date

Instructions:
1. Download form to your device.
2. Complete electronically.
3. Email to **intake@cbhcfl.org**