CHARLOTTE CBHC Behavioral Health Care

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.

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)

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:

- Right of Individual Dignity, which includes the right to be treated respectfully and to not be abused, to move freely within the facility unless their safety is at risk or their movement has been restricted by a judge, and the right to reasonable accommodations under ADA.
- Right to designate a representative that can be contacted in case of an emergency, to receive notice that you are at the facility, and if you need one but cannot choose for yourself we will select one on your behalf.
- Rights to communication to include the right to talk privately on the phone. If you are in an inpatient program you have the right to send and receive private mail. The facility is required to have reasonable rules about visiting hours, mail and use of the phone. If your access to any of these is restricted you will be given written notice that includes the reasons for the restriction. The restrictions will be reviewed every 7 days. You have the right to contact an attorney, the abuse hot line, or the Disability Rights department at any time
- Right to treatment and to receive the least restrictive, most appropriate and available treatment in this facility. You will get a physical exam within 24 hours or arrival to an inpatient unit. You will be asked to help develop a treatment plan that meets your needs.
- Right to Express and Informed Consent, including Information about treatment options before treatment begins. You will be given information about the purpose of treatment, the common side effects of medication you receive, alternative treatments, and the approximate length of stay at this facility. You, your guardian, guardian advocate or health care surrogate/proxy may withdraw your consent to treatment at any time.
- Right to your clothing and personal belongings when admitted to an inpatient setting unless they are removed for safety or medical reasons.
- Right to discharge from outpatient services. The right to request discharge from an inpatient program if you entered it voluntarily. Your doctors will be notified and you will be discharged within 24 hours from a community facility or within 3 working days from a state hospital, unless you change your mind or you meet the criteria for involuntary placement. A petition must be filed with the court within 72 hours of arrival, or 2 working days of your transfer from voluntary to involuntary status.

Acknowledgement of Receipt of Patient Rights

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

- Right to seek treatment from the professional or agency of your choice after your discharge from this facility.
- Confidentiality and privacy of information about your stay at this facility. Your information is private and may not be released without your consent or the consent of your guardian, guardian advocate, or health care surrogate/proxy if you have one, except under certain instances.
- Right to your clinical record, unless this is determined to be harmful to you by your physician.
- Access to legal representation and advocacy services. You or your representative have the right to ask the court to review the reason and legality of your detention in this facility, a denied legal right or privilege or a procedure that is not being followed.
- Right to register to vote and to cast your vote in any election unless the court has removed this right from you.
- Ability to file formal complaints and/or request changes in service delivery and receive a response within 24 hours of the conclusion of the investigation which may take up to 7 days.
- Right to present an advanced directive or to prepare a document when competent to do so that lists the mental health care that you want or don't want, and to name a person that can make decisions for you if you are unable to make those decisions for yourself.
- Right to receive services regardless of the inability to pay or whether payment of services is Medicaid, Medicare, or CHIP.
- Right to receive services no matter your race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.
- Liability and Immunity – 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. 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.

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.

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)]. Basic individual rights shall include [Reference 65D-30.0045(1)(a)1-10.]:

Acknowledgement of Receipt of Patient Rights

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

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

- The prominent posting of notices informing individuals of the grievance system. These are posted in main lobbies in outpatient buildings, in the adult and adolescent day rooms in the ARF, and in the day room at the Recovery Center (residential);
- Access to grievance submission forms;
- Education of staff in the importance of the grievance system;
- Education of staff in the importance of individual rights;
- Specific levels of appeal with corresponding time frames of resolution;
    - 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.
    - 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.
- Timely receipt of a filed grievance;
    - 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).
- The logging and tracking of filed grievances until resolved or concluded by actions of the provider's governing board;
    - 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.
- Written notification of the decision to the appellant; and
- Analysis of trends to identify opportunities of improvement.
    - 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

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)

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.

Specific to 65D-30, notification to all parties of these rights shall include [Reference 65D-30.0045(1)(b):

- Affirmation of an organizational non-relationship policy that protects the 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.
- Providers shall provide a copy to each individual receiving services.

_____ _____

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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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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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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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.

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****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