Renasiance Wellness Services, LLC Facesheet

Admit Date:	Date of Birth:	Social Security Number:		Record Number:
Last Name:	First Name:	Middle Name:		Maiden Name:
Physical Address:	City:	State:	Zip Code:	Home Phone Number:

Client's Legal Guardian

Guardian Last Name:	Guardian First Name:			
Physical Address:	City:	State:	Zip Code:	Home Phone Number:

Emergency Contact

Emergency Contact Last Name:	First Name:			
Physical Address:	City:	State:	Zip Code:	Home Phone Number:

Client Information

County of Residence:	Gender: ☐ Female ☐ Male
School Currently Attended:	Grade Level:

Race:

White (W) ☐ Asian or Pacific Islander (A) ☐

Black/ African American (B) ☐ Other (O) ☐

American Indian (I) ☐

Matial Status:

Never Married (S) ☐ Divorced (D) ☐

Married (M) ☐ Widowed (W) ☐

Annulled (A) ☐ Domestic Partners (L) ☐

Separated (P) ☐

Preferred Physician's Name:	Hospital Preference:
Address:	Phone Number:
Medical Conditions:	Medications:

Allergies:	Diagnosis Code:	Residence Type:
Discharge Date:	Target Population:	Referral Source:

8/15/2019

Renaissance Wellness Services Financial Form

☐ Admission ☐ Update ☐ No Changes

Client Last Name	First	Middle/Maiden	Record Number	Date

Primary Therapist

Annual Household Income (Including Self) ☐ 0-14,999 ☐ 15,000-24,999 ☐ 25,000-34,999 ☐ 35,000-44,999 ☐ 45,000-54,999 ☐ 55,000-64,999 ☐ 65,000-up

# in Household (including self)	Medicaid ID #	Health Choice ID #
Adults _____ Children_____		
Must attach a copy of all insurance cards (front and back), Medicaid card SIPS Printout (Where available)	Medicaid Effective Date	Health Choice Effective Date

Primary Commercial Insurance		Secondary Commercial Insurance	
Insurance Company		Insurance Company	
Policy Number		Policy Number	
Claims Mailing Address		Claims Mailing Address	
City, State, Zip		City, State, Zip	
Telephone #		Telephone #	
Insured Holder's Employer		Insured Holder's Employer	
Insured Holder's Name		Insured Holder's Name	
Insured Holder's DOB		Insured Holder's DOB	
Insured Holder's SS#		Insured Holder's SS#	
Client's Relationship to Insured	Self ☐ Spouse ☐ Child ☐ Other ☐	Client's Relationship to Insured	☐ Self ☐ Spouse ☐ Child ☐ Other

☐ **No Current Coverage**

DIRECT ASSIGNMENT FOR INSURANCE BENEFITS: I authorize Renaissance Wellness Services (RWS), as service providers or billing administrator, to file for my third-party insurance benefits for services provided to me or to my minor child. I authorize that the insurance benefits be made payable directly to RWS. A photocopy or electronic version of the assignment shall be considered as effective as the original. I authorize the release of my protected health information, or that of my minor child, for the purpose of filing for my insurance benefits, including the release of information relating to: the diagnosis and/or treatment of alcohol or substance abuse as protected by Federal Substance Abuse Confidentiality Regulations (CFR 42, Part 2), the diagnosis and/or treatment of psychiatric care and/or psychological assessment, and the diagnosis and/or treatment regarding human immunodeficiency sydrome (AIDS) or AIDS-related conditions as protected under the Health Insurance Portability and Accountablity Act of 1996 (HIPAA), 45 CFS, parts 160-164. I further authorize the release of information to utilization review organizations or agencies that provide managed care services for my insurance benefits.

_____ _____

(Client/Legally Responsible Person Signature Required) (Form is incomplete without signature) (Date Signed)

All the information I have provided is correct to the best of my knowledge. I agree to the conditions above.

☐ I request in accordance with the Health Insurance Portability and Accountability of 1996 (HIPPA), 45 CFR 164.522 that HIGHTS NOT contact my insurance carrier. In doing so, I understand that I will not be eligible for a reduced fee and will be responsible for payment in full at the time of service.

8-15-19

AUTHORIZATION TO GAIN AND/OR PROVIDE STUDENT INFORMATION

Student _____ Date of Birth _____

(Check one or both)

☐ **Authorization to Release Student Information to Orange County Schools from...**

☐ **Authorization for Orange County Schools to Release Student Information to...**

Agency or Individual _____

Address _____ Phone _____

Contact Person(s) _____

Information to be released:

☐ Academic _____ ☐ Transcripts _____

☐ Attendance _____ ☐ Medical/Psychological _____

☐ Behavior/Discipline _____ ☐ Assessment _____

☐ Exceptional Children Program Forms: Referral/Eligibility/Placement/Re-evaluation/IEP

_____

☐ Other _____

Purpose of Information Exchange _____

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

[I understand that electronic mail (email) is not confidential and may be intercepted and read by other people.]

Person Giving Consent:

_____ _____ _____

Name (please print) Signature Date

_____ _____

Mailing Address E-mail Address

_____ _____ _____ _____

Home Phone Work Phone Cell Phone Relationship to Student

School Information

Name _____

Address _____ Phone _____

Contact Person(s) _____

(name, title, phone extension)

A photocopy of this release shall be of the same force and effect as the original.

In accordance with the Family Educational Rights and Privacy Act (FERPA)

- Parents/Guardians (or students over the age of 18) have the right to inspect and review any and all official school records that directly relate to their child.
- Parents/Guardians may have a copy of released information if requested.

The authorized agency or individual agrees not to permit any other party access to the released information without parent/guardian or eligible student consent.

This authorization may be revoked at any time by so stating in writing, except to the extent action has previously been taken.

1/2011

Renaissance Wellness Services, LLC

"Awakening & Empowering the Spirit, Soul and Body"

CONSENT TO RELEASE INFORMATION

I hereby authorize Renaissance Wellness Services, LLC to **release, exchange, and receive** specified information regarding:

_____ to: _____

Client Name *Person, agency, referral source, other*

Client DOB: _____

Purpose of Release: Continuity of Care/ Coordination of Services

Information released may be verbal, electronic, or written.

Release data may include treatment notes. Nature of records to be released:

☐Clinical Assessment ☐AIDS/HIV Information ☐Discharge Summary ☐Alcohol/ Drug Treatment

☐Verbal Com. ☐Progress Note(s) ☐School related information/IEP

☐Psychiatric Evaluation ☐Medical History ☐Service Plan ☐Other:_____

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action, based on the consent has been taken. In accordance with 45 CFR 502 (b), Renaissance Wellness Services must make reasonable efforts to limit protected health information to the minimum necessary, except in cases when this may not apply. Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by law. I understand that if my records contain information relating to HIV infection, AIDS or AIDS related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure may include that information. This information will only be released in accordance with G.S. 130A-143.

_____ (initials, if applies only) I consent to release substance abuse and/or HIV/AIDS related information

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment of services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I understand that I may revoke this authorization at any time unless this authorization is given as condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or claim under the policy. In any event, if not revoked earlier this authorization expires on _____ or automatically not more than one year (365 days) from signature date.

I further understand that I may request a copy of this signed authorization

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Witness: _____ Date: _____

Renaissance Wellness Services, LLC Consent for Services
"Awakening & Empowering the Spirit, Soul, and Body"

Client Name:	Record #

INFORMED CONSENT

CONSENT FOR SERVICE: I consent to receive services from Renaissance Wellness Services, or I consent for the above child, youth, or incompetent adult to receive services. I understand that I will be made aware of the risks, benefits, and alternatives to treatment. If I, or the individual named above need emergency care while receiving services, I give permission for Renaissance Wellness Services (RWS) to obtain such care and I agree to be financially responsible for the services. I understand I have the right to a copy of my service plan.

I have read and understand the above, and freely consent and agree to all the foregoing conditions and information. I understand that this consent will remain in effect for the duration of treatment, and I may revoke it at any time except to the extent those services have already been provided.

SIGNATURE _____ DATE _____
(Client or legally responsible person)

CONFIDENTIALITY & CLIENT RIGHTS

CONFIDENTIALITY: The confidentiality of Client information is protected by both State and Federal Laws and Regulations. Renaissance Wellness Services is sensitive to and has an obligation to protect your right to privacy and is committed to holding confidential any information that you give us. Our staff cannot acknowledge their professional relationship with you to any person, including your family and friends without your written authorization or as an exception listed in the "Notice of Privacy Practices" brochure. Renaissance Wellness Services staff may discuss your situation with other professionals as part of your treatment process and to ensure that you are given the best possible care; however, will only do so within the guidelines of HIPAA, C.F.R. 42 and NC General Statutes.

NOTICE OF PRIVACY PRACTICES: This brochure was given to you today when you completed registration. It describes how Renaissance Wellness can and cannot use your medical record information. If you have a concern regarding your privacy, please contact Renaissance Wellness Services at _____ or call _____and ask for the Compliance Officer. A copy of this brochure can be located at our website at _____.

☐ **(please initial)** **I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES**

CLIENT COMPLAINTS: Renaissance Wellness Services provides a form for you to complete called "Client Complaint Resolution Form" if you have a complaint about services that you cannot resolve on your own. Please forward any complaints to the Compliance Officer at _____ or call _____.

CLIENTS RIGHTS: As a Client of Renaissance Wellness your rights are outlined in the brochure: "Your Rights as a Client".

☐ **(please initial)** **I HAVE RECEIVED THE CLIENTS RIGHTS BROCHURE**