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) (Date Signed)
(Form is incomplete without signature)

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

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**

CHATHAM
COUNTY SCHOOLS

REQUEST FOR VISITS FROM PRIVATE SERVICE PROVIDER

In general, students should meet with private medical, mental health, or other service providers off campus and outside of school hours. Private service providers are individuals hired by parents/guardians or other agencies to provide services to a student, and do not include contract service providers retained by Chatham County Schools or volunteers.

Per Public Schools Guidelines for Visits from Private Service Providers, exceptions to this rule may be granted for a student if requested by the parent/guardian and approved by a student support/intervention team and the school principal. In order to grant an exception, the student support/intervention team must determine that the service provider's visits (1) will not interfere with the learning of the student and/or other students or with the general educational environment, (2) will not disrupt the school environment or interfere with the delivery of instruction or services to any student, and (3) that the services to be provided are not substituting for appropriate special education or related services to be provided by Chatham County Schools.

Part A. Description of Services (to be completed by the parent):

I, _____, the parent/guardian of _____, a student at _____ (school), request that my child receive services from a private service provider on campus during the regular school day.

Name of provider:_____

Agency: _____

Services to be provided:

_____

_____

Proposed dates, times, and location of services:

_____

_____

_____ _____

Signature of Parent/Guardian Date

CHATHAM
COUNTY SCHOOLS

AGREEMENT AND WAIVER OF LIABILITY FOR PRIVATE SERVICE PROVIDERS VISITNG STUDENTS ON SCHOOL PROPERTY

Name of provider: _____

Agency: _____

Name of student: _____

School: _____

Services to be provided: _____

_____

Proposed dates, times, and location of services: _____

Provider agrees to the following:

- I understand that I am not an employee or agent of Chatham County Schools. With this agreement I hereby indemnify Chatham County Schools, its school board members, officers, agents, and employees from and against all claims, actions, demands, costs, damages, losses and/or expenses of any kind whatsoever, in whole or in part, resulting from or connected with my presence on Chatham County Schools property or my provision of services to the student named above.
- I agree to abide by any and all relevant Chatham County Schools policies while on District property, including but not limited to the Chatham County Schools Guidelines for Visits from Private Service Providers.
- I understand that this approval does not give me a right of access to any educational records related to the student named above or other students. I agree to keep confidential any student information I may learn while on school property.
- I understand that it is unlawful for anyone required to register as a sex offender under Article 27A of Chapter 14 of the General Statutes to knowingly be on the premises of any place intended primarily for the use, care or supervision of minors, including any school. This prohibition applies to persons required to register under Article 27A who have committed any offense in Article 7A of Chapter 14 or any offense where the victim of the offense was under the age of 16 years at the time of the offense.

_____ _____
Signature of Provider Date

_____ _____
Signature of Executive Director of Student Services Date

X_____ X_____
Signature of Parent/Guardian Date

P. O. Box 128 – 369 West Street – Pittsboro, NC 27312-0128 – Tel 919.542.3626 – Fax 919.542.1380
www.chatham.k12.nc.us

CHATHAM
COUNTY SCHOOLS

AUTHORIZATION TO DISCLOSE STUDENT INFORMATION

Student_____ **Date of Birth**_____ **School:**_____

Authorization to Release Student Information to Chatham County Schools:

Agency or individual _____

Address_____ Phone_____

Dates of service_____

Purpose of Information Request_____

Authorization for Chatham County Schools to release information to:

Agency or individual_____

Address_____ Phone_____

Purpose of Information Release_____

Information to be released:

- ☐ academic _____
- ☐ attendance_____
- ☐ behavior_____
- ☐ district testing_____
- ☐ non-district reports_____
- ☐ EC or MTSS Assessments_____
- ☐ transcripts_____
- ☐ other_____

Information of Person Giving Consent:

_____

Name (print) Signature Date

_____

Mailing Address Email address

_____

Phone (indicate home, work, or cell) Relationship to Student

Return Information to: _____

_____

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.