



Intake Checklist/Audit

- Facesheet
- Credit Card Authorization
- Informed Consent for Services & Acknowledgement of Rights & Privacy Practices
- Brochure of Client Rights, Privacy, and Confidentiality
- Consent to Release Information
- Consent to Release from School
- CCA Signed and Date
- Treatment Plan

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:
CHURCH LEAD/ 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: <input type="checkbox"/> Female <input type="checkbox"/> Male		
School Currently Attended:	Grade Level:		
Race:			
White (W) <input type="checkbox"/>		Asian or Pacific Islander (A) <input type="checkbox"/>	
Black/ African American (B) <input type="checkbox"/>		Other (O) <input type="checkbox"/>	
American Indian (I) <input type="checkbox"/>			
Matial Status:			
Never Married (S) <input type="checkbox"/>		Divorced (D) <input type="checkbox"/>	
Married (M) <input type="checkbox"/>		Widowed (W) <input type="checkbox"/>	
Annulled (A) <input type="checkbox"/>		Domestic Partners (L) <input type="checkbox"/>	
Separated (P) <input type="checkbox"/>			
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)
 Adults _____
Children _____
Medicaid ID #
Health Choice ID #

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	Client's Relationship to Insured
Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>

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 syndrome (AIDS) or AIDS-related conditions as protected under the Health Insurance Portability and Accountability 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.



Renaissance Wellness Services, LLC Credit Card Authorization Form

Name on Credit Card _____

Type of Credit Card (Circle one) Visa Mastercard Discover AmerE HAS

Card Number _____

Expiration Date _____

CVV Code _____ -- (three numbers on back of card)

Billing Address _____

Apt # _____ City _____ State _____ Zip Code _____

Phone Number _____

Email Address _____

Authorized User of Credit Card _____

Name _____

Company _____

Phone Number _____

Email Address _____

Type of Charge _____

Authorized Amount _____

Date of Charge _____

Authorization of Card Use

- I certify that I am the authorized holder and signer of the credit card referenced above. I certify that all the information above is complete and accurate.
- I hereby authorize collection of payment for all charges as indicated above. Charges may not exceed the amount specified above in "Authorized Amount" field. I understand this is only for up to the amount during the time period of "Date of Charge" referenced above. If additional charges are going to be authorized a new form will have to be completed.

Cardholder Name _____

Signature _____

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**



Name: Effective

SMC LME Client Record #:

For Day Treatment Services, document:

- There is an Axis I or II MH/SA diagnosis other than a sole diagnosis of a developmental disability.
AND
- For children with a substance abuse diagnosis, the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC) are met for Level II.1.
AND
- Both of the following shall apply:
 1. Evidence that less restrictive MH/SA rehabilitative services in the educational setting have been unsuccessful as evidenced by documentation from the school (e.g., Functional Behavioral Assessment, Functional Behavioral Plan, Individual Education Plan, 504 Plan, behavior plans).
 2. The child exhibits behavior resulting in significant school disruption or significant social withdrawal.
- AND**
- The child is experiencing mental health and/or substance abuse symptoms (not solely those related to an individual's diagnosis of developmental disability) related to his/her diagnosis that severely impair functional ability in an educational setting which may include vocational education.
AND
- There is no evidence to support that alternative interventions would be equally or more effective

Clinical Assessor's Signature with Credentials

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/>	<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Date
--	---

Printed Name of the Assessor with Credentials

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/>	<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Date
--	---

Consumer/Parent or Guardian Signature

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/>	
Print Name _____	Date _____



Treatment Plan

Client Full Name: DOB:		MR#: MID#/HC#:		Date:
Clinician and Client/Legally Responsible Person sign below whenever the plan is implemented/reviewed/revised.				
Date	Staff Signature	Date	I have participated in the development of the Service Plan and I agree with the plan (Client/Legally Responsible Person Signature)	
X	X	X	X	

Administration

Derrick D. Jordan, Ed.D.
Superintendent

Janice A. Frazier
Assistant Superintendent

Amanda J. Hartness, Ed.D.
Assistant Superintendent

Chris D. Blice
Chief Operations Officer

Tony M. Messer
Chief Finance Officer

Board of Education

Gary Leonard
Chair

Jane Allen Wilson
Vice-Chair

David Hamm

Melissa Hlavac

Del Turner



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

Administration

Derrick D. Jordan, Ed.D.
Superintendent

Janice A. Frazier
Assistant Superintendent

Amanda J. Hartness, Ed.D.
Assistant Superintendent

Chris D. Blice
Chief Operations Officer

Tony M. Messer
Chief Finance Officer

Board of Education

Gary Leonard
Chair

Jane Allen Wilson
Vice-Chair

David Hamm

Melissa Hlavac

Del Turner



**CHATHAM
COUNTY SCHOOLS**

AGREEMENT AND WAIVER OF LIABILITY FOR PRIVATE SERVICE PROVIDERS VISITING 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 _____
Signature of Parent/Guardian

X _____
Date



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:

- | | |
|---|---|
| <input type="checkbox"/> academic _____ | <input type="checkbox"/> non-district reports _____ |
| <input type="checkbox"/> attendance _____ | <input type="checkbox"/> EC or MTSS Assessments _____ |
| <input type="checkbox"/> behavior _____ | <input type="checkbox"/> transcripts _____ |
| <input type="checkbox"/> district testing _____ | <input type="checkbox"/> 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.