Client Chart Checklist

Left Side

- ❑ Client Chart Checklist
- ❑ Consumer Profile Sheets (Completed)
- ❑ Consumer Choice Form -Signed
- ❑ Renaissance Wellness Consent to Release -Signed & Dated
- ❑ Consent from School -Signed & Dated
- ❑ Privacy Practice - Signed & Dated
- ❑ Emergency Contact (Completed)
- ❑ Credit card authorization
- ❑ Medicaid card/ Insurance Information
- ❑ Medication/Allergies

Right Side

- ❑ CCA -Signed & Dated
- ❑ Treatment Plan -Signed & Dated
- ❑ Progress Notes added

Renaissance Wellness Services

Consumer Profile Sheet

Client Full Name:_____DOB:_____MR #_____

Address:_____

Phone Number:_____SSN:_____

MID#/HC#: _____Race:_____

Admission Date:_____Discharge Date:_____

Guardian:_____Relationship:_____

Address:_____

Phone Number:_____

Referral Source: _____Phone:_____

Physician:_____Phone:_____

Medical condition: _____Allergy:_____

Therapist:_____Phone: _____

School:_____Phone: _____

DJJ:_____Phone: _____

DSS:_____Phone: _____

Diagnoses:

Axis I: _____

Axis II:_____

Axis III:_____

Current Medications:_____

CHECK ALL THAT APPLY:

☐ HOMICIDAL/SUICIDAL IDEATION ☐ SUBSTANCE USE ☐ RECENT/MULTIPLE HOSPITALIZATIONS ☐ PROPERTY DESTRUCTION

☐ REFUSALS TO TAKE MEDICATIONS OR ATTEND PRESCRIBED APPOINTMENTS ☐ DISORGANIZED THOUGHTS AND/OR IMPAIRED JUDGMENT

☐ (INADEQUATE INCOME & NURTRITION, DANGEROUS LIVING ENVIRONMENT) ☐ INABILITY TO CARE FOR SELF ☐ FAMILIAL DYSFUNCTION

Renaissance Wellness Services

Consumer Choice Form

Client Full Name:_____ MR #:_____

MID#/HC#:_____DOB: _____

I, _____(consumer, guardian) have been informed of the appropriate and available providers in the Network of Cardinal Innovations Healthcare Solutions that would meet my specific needs for services, location, and hours of availability. I understand that only medically necessary services will be authorized. I I understand it is my choice to select an Endorsed Service Provider to address my needs and that I can alert my service provider if I would like to make a change. I can also call Cardinal Innovations Healthcare Solutions at 919-913-4000 to request assistance if I experience any difficulty with changing my service provider.

☒ I choose to receive **Outpatient Therapy Services** (services) from **Renaissance Wellness Services, LLC** and understand that someone from the agency/agencies will be contacting me within 7 days from the date of my signature on this form to initiate the service process.

☐ I choose to decline _____ services at this time. I have received procedures for accessing crisis services and understand the risk of declining these services.

Consumer: _____ Date: _____

Guardian: _____ Date: _____

Witness: _____ Date: _____

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: X _____ Date: X _____

Witness: _____ Date: _____

Client Full Name: _____ MR #: _____

MID#/HC#: _____ DOB: _____

Privacy Practices

Notice to Client or Guardian Regarding Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. As a consumer you are entitled to certain rights while receiving services.

All information that is provided during the screening, intake, and the treatment process is considered confidential by **Renaissance Wellness Services, LLC.** The disclosure of protected health information will be governed by the Health Insurance Portability and Accountability Act of 1996, federal law regarding substance abuse records 42 CFR Part 2, and all other exceptions identified in NC General Statute 122C 52-56.

I am required by law to protect your medical and personal information as well as information which may identify you. Information may include details about the health care that I am providing for you, payment for services, or information about your past, present, or future health concerns.

Disclosure of protected health information is permitted when you or your legal representative sign a written authorization, or give verbal authorization in an emergency situation. Any authorization for disclosure may be revoked at any time, except to the extent that action has been taken in reliance on it. In order to protect personal information to the best of my ability you will be asked to sign and date a consent to treat form and an authorization for the disclosure and reciprocal exchange of information contained in this packet.

With prior authorization I may use and disclose health information about you in order to provide accurate and effective services for you including coordinating health care interventions for you, in developing treatment goals with vested parties, and monitoring successes and progress. Case managers, therapists, guardians, and physicians are included as members of the treatment team and your health information may be shared between team members.

With prior authorization I may use and disclose health information about you to insurance companies in order to obtain payment for services provided. I may also disclose information before services are provided in order to obtain permission to provide certain interventions or services. Please be aware that any personal health information or diagnosis may be provided to an insurance company and may well become part of your permanent insurance record.

Under the following specific conditions, disclosure of information is permitted and/or required by law and professional ethics without your specific authorization

- I believe you to be a danger to yourself or someone else

Client Full Name: _____ MR #: _____

MID#/HC#: _____ DOB: _____

- You give me written permission to disclose information to other parties
- In the case of abuse to a child or an elderly person, your confidentiality will be waived
- If you want to seek reimbursement from a managed care company, the disclosure of confidential information may be required for reimbursement
- In case of a Medical Emergency
- In the case that I am responding to a court order or participating in a commitment proceeding.

You have the right to receive an accounting or listing of disclosures of health information in your medical record. These would include:

- the right to inspect and request a copy your medical record;
- the right to request amendment of any section of your medical record; and
- the right to receive an accounting of disclosures that have occurred with your medical record.

If you would like to receive an accounting you must submit a written request to myself.

I may mail information to you regarding appointment reminders, billing information, or other information about treatment alternatives, or services that might be of interest to you. If you do not wish to receive mailings please inform me.

I reserve the right to change this notice and to make the new notice effective for all protected health information that is maintained in hard copy or electronic format. Revisions to the PRIVACY PRACTICES will be made available to you.

Renaissance Wellness Services, LLC recognizes the importance of confidentiality, and your right to be fully informed of all regulations regarding protected health information. If you feel that your privacy rights have been violated you may contact the Secretary of the North Carolina Department of Health & Human Services, Mail Service Center 3015, Raleigh, North Carolina 27699, or 919-715-1294; or Disability Rights North Carolina, 2626 Glenwood Avenue, Suite 550, Raleigh, North Carolina 27608; or 877-235-4210. Provision of services will not be affected by the filing of any complaint.

Thank you for reviewing the policies outlined above. By signing the following form you acknowledge that you have received a copy of the policies and have an understanding of their contents. I look forward to this opportunity to work and grow together.

Consumer: _____ Date: _____

Guardian: _____ Date: _____

Witness: _____ Date: _____

Renaissance Wellness Services, LLC

Emergency Fact Sheet

Client: _____ Date of Birth _____

Record Number: _____

Medical Condition (If Any) _____

Current Medications (last three months)_____

County of Residence: _____

Allergies: Yes: ___ No: ____ If so explain: _____

Sex: F: ____ M: ___ Race:_____

Legally Responsible Person: _____

LRP Home Address:_____

LRP Phone: Work_____ Home:_____

Cell:_____

Person to be contacted in case of an Emergency:

_____

Phone:_____

Relation:_____

Preferred Physician _____

Physician Address _____

Comments: _____

_____

_____

Staff Signature _____ Date _____

Client (Guardian) Signature X_____ DateX_____

Renaissance Wellness Services

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

Client Full Name: _____ MR #: _____

MID#/HC#: _____ DOB: _____

Diagnosis

AXIS	CODE	TYPE	DESCRIPTION
AXIS I			
AXIS II			
AXIS III			
AXIS			

RECOMMENDATIONS (Check all that apply)

☐Targeted CM ☐Community Support Team ☐Group Therapy ☐Intensive In-Home Services ☐IDDT ☐ Individual Therapy ☐Family Therapy ☐Family Psycho-Ed ☐Wellness/Illness Management and Recovery ☐Mobile Crisis ☐Substance Abuse Tx. ☐Day Tx ☐ACTT ☐PSR ☐Sex Offender Specific Assessment ☐Psychiatric Eval. ☐Med. Management ☐Psychological Testing ☐Educational Testing ☐Supported Living ☐Emergency Services ☐Domestic Violence Treatment ☐Parenting Skills ☐DD Targeted Case Management ☐CAP funding ☐Developmental Therapies ☐Interpreter Services ☐Health/Medical ☐Dental Ref. ☐Vocational Rehabilitation ☐Alateen /Alanon ☐Gambling Anonymous ☐AA/NA ☐DJJ Involvement ☐DSS referral ☐Faith Based referral ☐Section 8 Housing ☐SSI determination Home Health Care ☐Child Advocacy ☐Legal Assistance ☐Veteran Services ☐IEP/SAP referral ☐Other community resources –

Other natural supports -

Individuals Participating in Assessment

NAME	Relationship	Date
Print Name:	**Consumer**	
Signature:	**Consumer**	
Print Name: X	**Guardian (if indicated)** X	
Signature: X	**Guardian (if indicated)** X	

Clinician Signature/Title/DATE:

Family preference of where services occur:

Clinician recommendations on where services occur:

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 _____

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

Appointment reminder for calls/text

Dear Parent(s),

This letter is to inform you about our automated system, that will send out a text message and a phone call to remind you of your child's appointment with their therapist at their school. Please confirm by pressing 1 or 2 to cancel, no further action is needed on your behalf.

Thank you,
Renaissance Wellness Services, LLC

_____

Therapist Signature

_____

Parent(s) /Guardian

Recordatorio de cita para llamadas / texto

Queridos padre(s),

Esta carta es para informarle sobre nuestro sistema automatizado, que enviará un mensaje de texto y una llamada telefónica para recordarle la cita de su hijo con el terapeuta de su hijo/a en su escuela. Confirme presionando 1 o 2 para cancelar, no es necesario realizar ninguna otra acción.

Gracias,
Renaissance Wellness Services, LLC

_____
Firma del terapeuta

_____
Padre (s) / Guardián