United Quest Care Services, LLC

"Providing Effective Cultural & Competent Care"

MEMBER EMERGENCY INFORMATION SHEET

I,_____, member/parent/guardian do authorize United Quest Care Services, LLC staff members to seek emergency medical treatment and to execute any document necessary for treatment. In the case of sudden illness or accident, all employees of UQCS, LLC have been instructed to take member to the requested:

Hospital/emergency facility of choice:_____ **at (** **)** _____and notify member's physician and the emergency contact.

Member name: _____ Phone: _____

Address: _____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ SS#: _____

Chronic llnesses:_____

Allergies: _____

Guardian: _____ Phone:_____

Address: _____ City:_____ State:_____ Zip:_____

Insurance:_____ Policy #:_____ Group #:_____

Insurance:_____ Policy #:_____ Group #:_____

Current Psychiatric Medications*(Please attach medical medications on additional sheet):*

Date	Medication Name	Dosage	Frequency	Use	Prescribed Physician

In the event of an emergency, persons authorized to be contacted or pick up member:

_____ Name _____ Relationship _____ Phone

_____ Name _____ Relationship _____ Phone

Primary Care Physician:_____ Phone:_____

Psychiatrist:_____ Phone:_____

Therapist:_____ Phone:_____

Signature of Member/Guardian: Date:
Member's Printed Name:

United Quest Care Services, LLC

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CONSENT FOR RELEASE OF MEMBER INFORMATION

To Permit Use and Disclosure of Health Information

This authorization from implements the requirements for Member authorization to use and disclose Health Information protected by the Federal Privacy Law, (HIPPA) 45 C.F.R. parts 160-164; the Federal Confidentiality Law, 42 C.F.R. part 2, and state Confidentiality Law governing Mental Health, Developmental Disabilities, and Substance Abuse Services G.S. 122 C.

Member:	DOB:
Record Number:	SSN:

Requests and authorizes, United Quest Care Services, LLC to use or disclose the Protected Health Information indicated below (including HIC & Substance related information is applicable) to:

PCP-Physician Name:_____Phone:_____

Please indicate information to be disclosed:

_____ Admission/Screening Assessment _____ Service Plan _____ Service Note

_____ Medication HX Physicians _____ Psychological testing _____ HIV Related Info

_____ Discharge Information _____ Substance Abuse Info _____ Psychiatric Eval

_____ 3rd Party Info _____ Accounting of Disclosure _____ 508 DWI Form

Other Information (if not listed):_____

Purpose of disclosures: ____Continuity of Care _____Referral _____Legal _____ Service delivery _____ Other:_____

- I understand that the health information used and disclosed may include information such as HIV infection, AIDS-related conditions, alcohol abuse, drug abuse and psychological or psychiatric conditions. I authorize release of information regarding HIC or AIDS-related conditions. (HIV or other communicate disease related Information may be a part of multiple documents in the record.)
- I understand that once information is disclosed pursuant to this Authorization, it is possible that it will not be protected by state and federal privacy and confidentiality laws and that it could be re-disclosed by the person or agency that receives it.
- I understand that by indicating I authorize 3rd Party Information to be disclosed, any Protected Health Information (PHI) from other treatment facilities contained in this medical record will be shared pursuant to this authorization, including substance abuse information.
- I understand with certain exceptions; I have the right to revoke this authorization at any time (orally or by submission of written notification). This procedure for revoking authorizations as well as the exceptions to my right to revoke is explained in United Quest Care Services, LLC Notice of Privacy Practices. If you do not have the Notice of Privacy Practices, you may request one from the receptionist.
- The meaning of this authorization form has been explained to me. I understand that I may refuse to sign this authorization form. I understand that United Quest Care Services, LLC will not condition treatment on receiving my signature on this authorization. I understand this authorization is made freely, voluntary and without coercion. I understand the Health Information indicated will be disclosed per my instructions.

This authorization is effective only for the following period of time (not to exceed 12 months)

From: _____ To: _____

My authorization is withdrawn if any of the following occur: Event:_____

Signature of Member/Guardian:	Date:
Witness:	Date:

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Member:	DOB:
Record Number:	SSN:

Requests and authorizes, United Quest Care Services, LLC to use or disclose the Protected Health Information indicated below (including HIC & Substance related information is applicable) to:

Emergency Contact: _____Relationship:_____

Phone Number:_____

Please indicate information to be disclosed:

_____ Admission/Screening Assessment _____ Service Plan _____ Service Note

_____ Medication HX Physicians _____ Psychological testing _____ HIV Related Info

_____ Discharge Information _____ Substance Abuse Info _____ Psychiatric Eval

_____ 3rd Party Info _____ Accounting of Disclosure _____ 508 DWI Form

Other Information (if not listed):_____

Purpose of disclosures: _____ Continuity of Care _____ Referral _____ Legal _____ Service delivery _____
Other_____

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Signature of Member/Guardian:	Date:
Witness:	Date:

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Member:	DOB:
Record Number:	SSN:

Requests and authorizes, United Quest Care Services, LLC to use or disclose the Protected Health Information indicated below (including HIC & Substance related information is applicable) to:

Contact: _____Relationship:_____

Phone Number:_____

Please indicate information to be disclosed:

_____ Admission/Screening Assessment _____ Service Plan _____ Service Note

_____ Medication HX Physicians _____ Psychological testing _____ HIV Related Info

_____ Discharge Information _____ Substance Abuse Info _____ Psychiatric Eval

_____ 3rd Party Info _____ Accounting of Disclosure _____ 508 DWI Form

Other Information (if not listed):_____

Purpose of disclosures: _____ Continuity of Care _____ Referral _____ Legal _____ Service delivery _____ Other_____

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My authorization is withdrawn if any of the following occur: Event:_____
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Signature of Member/Guardian:	Date:
Witness:	Date:

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NOTICE OF HIPAA REGULATIONS

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), also known as HIPAA, was enacted as a Congressional attempt to reform healthcare. The purpose of the Act is to:

- Improve portability and continuity of health insurance coverage in the group and individual markets;
- To combat waste, fraud, and abuse in health insurance and health care delivery;
- To promote the use of medical savings accounts;
- To improve access to long-term care services and coverage;
- To simplify the administration of health insurance; and
- Other purposes

Title I of the HIPAA law deals with health care access, portability, and renewability with the intention of protecting health insurance coverage for workers and their families when they change or lose their jobs. Title II of the law, also known as "Administrative Simplification," deals with preventing health care fraud and abuse.

The "Administrative Simplification" aspect of that law requires the United States Department of Health and Human Services (HHS) to develop standards and requirements for maintenance and transportation that identifies individual members. These standards are usually referred to as "HIPAA Regulations."

These regulations are designed to:

- Improve the efficiency and effectiveness of the healthcare system by standardizing the interchange of electronic data for specified administrative and financial transactions; and
- Protect the security and confidentiality of electronic health information.

The requirements outlined by the law and the regulations promulgated by DHHS are far-reaching. Healthcare organizations that maintain or transmit electronic health information must comply. This includes health plans, health care clearinghouses, and healthcare providers who submit claims electronically. After each final regulation is adopted, small health plans have 36 months to comply. Others, including healthcare providers, must comply within 24 months.

The HIPAA transaction rules will require that everyone use the same format to transmit health-related information. Claims submission, claims status reporting, referral certification and authorization, and coordination of benefits will be affected. What does this mean for medical practices? Practices will have to ensure that their software vendors have implemented the required HIPAA changes so they can send and receive information using the standard formats. Because most software vendors already use the standard formats, this regulation shouldn't have much impact on daily practices, except perhaps to make electronic data interchange preferable to (i.e., less expensive than) paper processing for providers and health plans alike. HIPAA has been instituted to provide greater protection of member confidentiality, the regulations will require that you take a number of administrative measures to ensure that any member-identifiable information, referred to by HIPAA as "protected health information" (PHI), in your practice is secure.

HIPAA's purpose, regulation and functioning have been explained to me.

PANDEMIC SCENARIOS: Per State Guidelines, flexibility on service delivery can be modified in certain pandemics i.e. telehealth and telephonic services. Nationwide Public Health Emergency, covered health care providers may use non-public facing applications that allow for using telecommunications technology for two-way, real-time interactive communication. Providers will notify Members that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications. I give permission to use modified service delivery for compliance with treatment recommendations.

Signature of Member/Guardian: Date:
Member's Printed Name:

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Member Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, United Quest Care Services, LLC. may create and maintain health records and other information describing among other things, my health history, progress toward goals evaluation and assessment results, crisis events, services or treatment, and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a complete description of the uses and description of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice, practices, and prior to imp will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.
This consent is given freely with the understanding that:
1. Any and all records whether written or oral or in electron format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations are restricted. I also understand that United Quest Care Services, LLC and I must:

- Agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information;
- And agree to terminate any restrictions in wilting on the use and disclosure of my Protected Health Information which have been previously agreed upon.
- I acknowledge that I have been provided a copy of the Notice of Privacy Practices for United Quest Care Services, LLC
- I understand that the Notice of Privacy Practices discusses how my personal health care information may be used and/or disclosed, my rights with respect to health care information, and how and where I may file a privacy-related complaint.
- I may review a copy of the Notice in the waiting room of United Quest Care Services, LLC
- I may obtain a copy of this from United Quest Care Services, LLC
- I understand that the terms of this Notice may be changed in the future, and these changes will be posted in the waiting room of United Quest Care Services, LLC I may also request a copy of the new Notice by contacting the Privacy Officer.

Signature of Member/Guardian:	Date:
Member's Printed Name:	

Notification of Receipt of Member Rights

I understand the contents regarding member rights and responsibilities. I have received a copy of the confidentiality notice, Member Handbook (which includes a summary of my rights), Appeals Steps Process and Flow Chart (Medicaid members only), and Program Rules. I received an explanation of the services, including the benefits and risks, program rules and grievance procedure. I also understand that at any time I feel treatment/services are not beneficial to me or my child, I may withdraw from United Quest Care Services, LLC Staff has answered my questions regarding member's rights.

I also understand that specific programs may have additional policies and procedures pertaining to member rights and that those will be explained to me upon entry into the program.

Signature of Member/Guardian:	Date:
Member's Printed Name:	

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Telemedicine Session: Member/Member's Authorization and Consent Form

Definition and Details

Telehealth refers to medical/clinical services that are provided remotely using videoconferencing or telephone. To participate in videoconferencing, there is necessary technology, hardware, software, internet access, and competency with technology that is required. You as the member or legal caregiver together with the provider will determine the best form of telehealth to use during your sessions based on access, your preference, and clinical indications. If you will be using videoconferencing sessions, you will receive the appropriate instructions in advance.

You or the minor member are entitled to the same rights and have the same responsibilities as with in-person sessions. Providers will maintain the same level of ethical conduct and protection of privacy, including the maintenance of records, as with in-person sessions.

Benefits

Benefits of telehealth include: a) you and your provider do not have to be in the same physical location, promoting more consistent visits and easier access to care, b) saving time and money involved with traveling to and from appointments, c) telehealth can be as clinically effective as in-person services, d) allowing for clinical visits to continue in the context of social distancing recommendations related to infectious outbreaks.

Your Telemedicine Session

Telemedicine lets a doctor or other healthcare provider care for you, even when you cannot see him or her in person. The doctor uses the Internet or other technology to: give you advice, give you an exam, or do a procedure through online communications.

Telemedicine can also be used to: get prescription refills, book an appointment, or let your doctor talk with other providers about your health problem or treatment.

Telemedicine is more than a phone call, an email, a fax, or an online questionnaire. Sometimes you may need to come to a healthcare facility to use their equipment (TV screen, camera, or Internet). A provider may use need to use technology tools or medical devices to check on your health remotely. If you agree, part of your health record may be sent to the telemedicine provider before your session.

You and your healthcare team must decide if your health problem can be helped with telemedicine. The team and others involved in your care (e.g., medical home or hospital teams) will make a plan for your care using telemedicine. This will also include a plan in case you have an emergency during the telemedicine session.

If the member is a minor child, the telemedicine provider will explain to the parent how a telemedicine exam is different from an in-person exam. He or she will also explain if a complete exam of the child is possible.

During your telemedicine session:

1. The provider and the staff will introduce themselves.
2. When starting a session, you may be asked to confirm the state you are in and the state where you live.
3. The provider may talk to you about your health history, exams, x-rays, and other tests. Other providers may take part in this discussion.
4. A visual and/or partial physical exam may take place. This may happen by video, audio, and/or or with other technology tools. A nurse or other healthcare staff may be in the room with you to help with the exam.
5. Non-medical staff may be in the room to help with the technology.
6. Video and/or photo records may be taken, and audio recordings may be made.
7. A report of the session will be placed in your medical record. You can get a copy from your provider.

All laws about the privacy of your health information and medical records apply to telemedicine. These laws also apply to the video, photo, and audio files that are made and stored.

Risks

1. Confidentiality. The provider will ensure that your sessions are private and confidential to the extent possible. However, there may be challenges with confidentiality using telehealth including: the potential for others to overhear and/or oversee sessions on your end, as well as technology-related issues (e.g., others accessing your private conversations or stored information without your knowledge). It is recommended that you are in a private and quiet place during your session. When possible, use a secure internet connection rather than public/free Wi-Fi to protect your privacy. The sessions will not be recorded without your permission.
2. Interruptions during sessions. (a) While privacy is a priority during telehealth, unexpected interruptions may be more likely to occur outside of the provider's office. (b) Technology may unexpectedly stop working during a session. If the connection is lost during a session, your provider will try to reconnect with you immediately and then every 5 min for 15 minutes or until your session time has expired, whichever comes first. If your provider is unable to reconnect with you during the session time and the situation is not urgent, your provider or proxy will reach out to reschedule or schedule a follow-up appointment. If you are disconnected from your provider and your provider is unable to immediately reach you during an urgent or emergency situation, your provider will attempt to reach your emergency contact person and might call 911 or

the Mobile Crisis Unit (for behavioral health issues) to respond, if necessary. In the event that your provider is unable to reach you and you are still in need of emergency assistance, you should call 911 or the mobile crisis unit (for behavioral health issues), or have someone take you to an emergency department.

3. Effectiveness. Most research shows that telehealth is effective. However, certain aspects of telehealth may be different and less ideal compared with in-person sessions. For example, it may be more difficult for the provider to pick up on nonverbal communication during telehealth compared with in-person sessions.
4. Crisis Management. It can be more difficult and riskier to manage a crisis situation via telehealth versus in-person sessions. However, during periods of infectious outbreak with social distancing recommendations, telehealth services may be available to you if you are experiencing a more critical situation. To ensure your safety, the following measures will be taken:

1. At the beginning of the session, you will be required to inform the provider of your location address in case of emergency.
2. You will be required to inform your provider of the name and phone number(s) for at least one emergency contact person, who may be contacted in case of emergency. In the case of a minor, this is usually the legal caregiver.
3. If you are at high medical or psychiatric risk as determined by your provider, then the provider might require that there is a responsible adult located close by during your sessions.
4. If you are at high medical or psychiatric risk, the provider will work with you to develop an emergency response plan to address potential crisis situations that might arise during your sessions.

If there is an active crisis during your visit, or if your provider is concerned about serious risk of harm to you or others, the provider may call the emergency contact person, 911 or the Mobile Crisis Unit (for behavioral health issues). For minor members, a parent or legal caregiver might be instructed to bring the member to an emergency department

More Facts

1. The main goal of telemedicine is to make sure that you get good, personal health care, even though you are not seeing a provider in person.
2. Some states may require you to have a face-to-face visit first and a yearly visit with your doctor before telemedicine treatment can happen.
3. Telemedicine providers must follow the same rules for prescribing drugs just as they would for an office visit. Before your session, you will learn about which drugs telemedicine providers can and cannot prescribe.
4. Having a telemedicine session is your choice. Even if you have agreed to the session, you can stop your medical records from being sent – if this has not happened yet. You can stop the session at any time. You can limit the physical exam.
5. You will be told about all staff who will take part in the session. You can ask that any of these people leave the room to stop them from seeing or hearing the session. It is up to you to make sure the setting for your session is private. It should only include people who you are willing to share health information with. Your telemedicine provider can ask that people with you leave the room to make sure your session is private.
6. Your session may end before all problems are known or treated. It is up to you to get more care if your health problem does not go away.
7. You will be told how long it might take to respond to your emails, phone calls, or other types of messages.
8. Before your session, you may want to ask how much of the cost will be covered by your insurance and how much you may owe.

Financial:

Telehealth is a billable service, and insurance or you (if no insurance) will be billed accordingly. Fees for telehealth may be comparable to in-person session fees. Most insurance companies have wider coverage of telehealth during infectious outbreaks. Check with your insurance company and/or behavioral health plan or the billing department at WFBH for more information. There may be additional costs incurred during telehealth visits due to data usage or technology, and you or legal caretaker(s) are responsible for such costs.

Attestation

I have been advised of all the potential risks, consequences, and benefits of telehealth. My provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all my questions have been answered. I understand the information provided herein. I understand that no guarantees have been made about success or outcome, and I agree to take part in a telemedicine session.

Signature of Member(Member)/Guardian:	Date:
Member(Member)'s Name:	