United Quest Care Services, LLC

Please "N/A" or "None" if an area does not apply!

"Providing Effective Cultural & Competent Care"

CLIENT EMERGENCY INFORMATION SHEET

I,_____, client/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 client to the requested:

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

Client 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 client:

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

Primary Care Physician:_____ Phone:_____

Psychiatrist:_____ Phone:_____

Therapist:_____ Phone:_____

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

United Quest Care Services, LLC

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Psychiatric Advance Directives Form

Consumer:	DOB:
Record Number:	SSN:

Advance Directive/Instruction means "a written instrument, signed in the presence of two qualified witnesses who believe the principal to be of sound mind at the time of the signing, and acknowledged before a notary public, pursuant to which the principal makes a declaration of instructions, information, and preferences regarding the principal's mental health treatment and states that the principal is aware that the advance instruction authorizes a mental health treatment provider to act according to the instruction. It may also state the principal's instructions regarding, but not limited to, consent to or refusal of mental health treatment when the principal is incapable."

I, _____ have an Advance Directive.

I, _____ like to have an Advance Directive Form to complete.

I, _____ have a legally person designated to act on my behalf in case of mental health incapability.

If a person is designated person to act on consumer's behalf, then please list:

Name: _____

Relationship: _____

Phone number: _____

Address: _____

City:_____ **State:**_____ **Zip:**_____

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

United Quest Care Services, LLC

"Providing Effective Cultural & Competent Care"

CONSENT FOR TREATMENT/SERVICE PROVISION

This form is to document that I, _____, give my permission and consent to the above named agency to provide clinical support and skill building interventions to me or to my minor child (if client is a minor).

I fully understand that because of factors beyond the agency's control or other factors, such benefits and particular outcomes cannot be guaranteed.

I understand that because of the counseling and/or other services being provided, I (or my child) may experience emotional strains or feel worse at some points during treatment. I realize that because the ultimate goal is to make positive life changes; reaching these changes may at times be very uncomfortable for me (or my child) initially.

I understand that coordination of care is needed for the best care possible for me (or my child).

I know of no reason that I (or my child) should not undertake this counseling and/or skill building service and I agree to full participation. I further understand that I may revoke this consent and discontinue my treatment at any time I so desire.

In signing this document, I am stating that I have read and agree to the following conditions regarding services rendered by United Quest Care Services.:

1. I consent to and authorize treatment through United Quest Care Services, LLC.
2. I authorize the collection of necessary data regarding me and/or my child. I understand that such data shall be computerized for statistical, programming, and billing purposes.
3. I understand information regarding me shall be collected and maintained in a confidential clinical record. Any such records or information shall remain confidential except in the following incidences:
4. Information required by third party payers shall be forwarded to them.
5. Records shall be open to United Quest Care Services, LLC staff as needed, and to appropriate state mental health and substance abuse officials.
6. Information may be exchanged if I sign a written release form indicating the nature of information to be released.
7. Information, which indicates a severe threat to the life or safety or another person or to self, shall be forwarded to the threatened parties or appropriate agencies to the extent necessary to protect life and safety.
8. Information will be released if required under a court subpoena.
9. Suspected abuse or neglect shall be reported to Protective Services as mandated by the Code of North Carolina and Federal Law.
10. State and Federal law prohibits the disclosure of any information identifying a consumer as receiving alcohol/drug services unless the consumer consents in writing, the disclosure is allowed by court order, disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluations.
11. Federal Law does not protect any information about a crime committed by a consumer either at the program or against any person who works for the program or about any threat to commit such a crime.
12. I understand that all services will be provided regardless of gender, color, national origin, sexual orientation, religious preference, and a level of disability.
13. If there is a medical or psychiatric emergency, I give permission for staff to seek emergency care on my behalf.
14. United Quest Care Services, LLC staff may share information with my consent with other associated facilities such as group homes, Dept. of Social Services, Court Services, and Area Programs if a consumer is seen in two or more of these agencies. I understand there may be instances in which pertinent information may be disclosed without my express written consent, such as medical emergencies or in assuring I receive appropriate continuing care (for example, to a hospital, a county department of Social Services or a county Department of Public Health).
15. I agree to satisfy my financial obligation with United Quest Care Services, LLC I understand payment is due at the time services are rendered, unless payment arrangements are made.
16. I agree that I may be requested to utilize PPE equipment in the event of being sick or in a pandemic scenario.
17. I agree to telehealth services and equipment to provider treatment services and events.

Provider Choice:

Other:

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

United Quest Care Services, LLC

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SCREENING/ADMISSION ASSESSMENT

Admission/Enrollment Effective Date:_____

Referral Source:_____

A. Identifying Information:

Client Name:_____ Rec. No:_____ SSN:_____

DOB:_____ Age:_____ Race:_____ Gender:_____ Marital Status:_____

B. Reason for Admission:

_____

_____

C. History of Treatment:

Is Client Currently Receiving Services From Other Agencies? Agencies:_____

Has Client Been Seen Within this Agency Previously? (Program):_____

Nature (onset, recent changes, etc.) of Presenting Problem or Situation:

_____

_____

D. Social, Family, Medical History:

1. Social:

Education: Highest Level:_____

Veteran Status:

Legal Problems: Explain: _____

Employment Status:

Other: _____

Occupation:_____ Employer:_____

Identified Racial, Ethnic, and Cultural issues which dictate treatment considerations: (i.e. communication difficulties):

_____

_____

2. Family:

Health of Parents: (Mother) (Father)

Siblings #:_____ Number of Marriages:_____ Spouse/Partner's Name:_____

Children: Number of Daughters: _____ Ages: _____ Number of Sons: _____ Ages:_____

Additional Family Information: _____

_____

History of Familial Physical/Sexual Abuse, Violence, Mental Illness, or Developmental Disabilities: _____

_____

_____

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3. Medical:

Past Hospitalizations (include dates): _____

Present Medications (Both Prescribed and Over-the-Counter; include dosage): _____

_____

_____

Allergies: Food: _____ Drug:_____

Primary Care Physician:_____ Address:_____

Phone Number:_____

Date of Last Physical: _____

Weight: _____ Height:_____

Nutritional Assessment:

History of/Presently Have: _____Seizures _____Ulcers _____Diabetes _____Heart Problems _____TB _____Chronic Pain

_____Hypertension _____Currently pregnant _____Liver Problems _____Asthma _____Thyroid Problems

_____STD's (including HIV): _____

_____Other: (list) _____Explain: _____

List your major health concerns in order from importance:_____

_____

Diet: _____Vegetables _____Fruit _____Breads _____High Sugar _____Coffee _____High Fat _____Dairy _____Tea

_____Vitamins _____Water _____Meat _____Fish _____Soda _____Fried Food _____Fast Food

☐Other:_____

Exercise: _____

Sleep Patterns: _____

Incontinence: _____ Constant Urination at night: _____

Recent weight gain/amount:_____ Recent weight loss/amount:_____

Pain Assessment:

1. Does the consumer (currently) feel pain anywhere in their body? _____
   (If the answer is "no", skip the remainder of this section)
2. Can the consumer describe where in their body the pain is located?_____
3. On a scale of 1 to 10, with 1 (being no pain) and 10 being (intolerable pain), how would the client rate the pain that they experience? _____
4. What is the onset of the pain? (I.e. rainy day)_____

   _____
5. Are you under the care of a physician? If so, whom?

   _____

   _____

E. Abilities, Strengths, Preferences:

1.Abilities: _____

2.Strengths: _____

3.Preferences_____

4.Goals:_____

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F. Mental Health History

Previous Psychiatrist:
Name:_____ City:_____ State:_____ Discharge Date:_____
Name:_____ City:_____ State:_____ Discharge Date:_____

Psychiatric Hospitalizations Date(s) and
Place(s):_____
_____

Suicidal Assessment:

1. Does patient have a history of suicidal ideation? _____ If so, when? _____
2. Has the patient ever been hospitalized for suicidal ideation? If yes, please explain when, where and why?
   _____
   _____
3. Is there any history of suicide in the family? _____ If yes, please explain who, when and where:
   _____
   _____
4. Does Patient have any psychiatric diagnoses? _____ If yes please list.
   _____
   _____
5. Environmental Triggers

   Lost job: _____ Lost home: _____ Financial: _____ Death of family or friend: _____
   Employment: _____ Divorce: _____ Other:_____

   Is there a family history of suicide? _____ If so, whom? _____
   _____
6. Please rate the client's risk for suicide(0 out 10): _____

Guideline: In the event that the consumer is at risk, please refer to a psychiatrist for further evaluation immediately.

G. Substance Abuse History:

Tobacco Use: _____ Type: _____ Cigarettes _____ Pipes/Cigars _____ E-Cigars _____ Chewing tobacco Frequency:_____

Client Drug Use: _____ Drug 1#: _____ Age at first use:_____ Date of Last Use: _____

Route: _____ Oral _____Smoking _____Inhalation _____Injection ☐Other: _____

Frequency: _____ Amount Used: _____

Drug 2#: _____ Age at first use:_____ Date of Last Use: _____

Route: _____ Oral _____Smoking _____Inhalation _____Injection ☐Other:_____

Frequency: _____ Amount Used: _____

S/A Treatment: _____ Date(s) and Place(s): _____
_____

H. Preliminary Service Recommendations:_____

_____ _____
Provider's Signature/Credentials Date

United Quest Care Services, LLC

"Providing Effective Cultural & Competent Care"

PROGRAM REQUIREMENTS AGREEMENT FORM

I agree to adhere by the following program requirements in order for me/my child to remain an active participant in our Enhanced services program(s).

1. I agree to attend and participate in all Person-Centered Planning Meetings.
2. I agree that my support staff may have to make home visits to support in the community.
3. I agree to keep my Qualified Professional informed of any changes in my address, phone number or insurance information.
4. I agree to provide United Quest Care Services with a copy of my Insurance card on a yearly basis before and after expiration.
5. I agree to take an active role in my/my child's treatment and provide invaluable feedback and share important information that will promote recovery and success.
6. I agree to adhere to the schedule of services originally agreed upon unless a regularly scheduled service date falls on a company holiday and I elect not to participate in services.
7. I am aware of the First Responder/Crisis Response procedure, and I have been informed that there shall be 24 hr/365 days of access to Case workers and/or clinical backup by any active staff members of United Quest Care Services, LLC and I will receive a copy of my child's Crisis Plan to assist me in Emergency Situations and emergency contact numbers.
8. I agree that I may be requested to utilize PPE equipment in the event of being sick or in a pandemic scenario.

TRANSPORTATION RULE

I hereby give my permission for transportation to be provided by United Quest Care Services, LLC staff. I understand that transportation will be provided only when other private and public resources for transportation are exhausted.

I understand all staff is required to have a valid North Carolina driver's license and current vehicle insurance. Staff shall exercise caution when transporting, and adhere to the traffic laws of North Carolina.

It is understood and agreed that the said staff will be held harmless in case of accident or injury to the consumer while participating in supervised program activities, and while being transported to and/or from school, court, and community agencies.

I understand that acceptance of transportation is at my own risk.

CONSENT TO TRANSPORT

(To include out of town/state)

I have had the opportunity to read the transportation rules and procedures of United Quest Care Services, LLC With full understanding of such rules and procedures, and with awareness of the hazards inherent in automotive transportation, I hereby voluntarily give consent for transportation by United Quest Care Services, LLC, its successors and assigns, and its directors, employees and representatives, severally and individually from all claims, demands, damaged, actions and from any and all liability of any nature whatsoever for any loss, damage, injury, harm or complication of any kind that I may sustain as a direct or indirect result of my using any transportation services provided by United Quest Care Services, LLC, or by any other individual under the direction of, or under the supervision of, employees of United Quest Care Services, LLC

(To be signed by consumer/legally responsible person prior to admission, if possible, but at least 24 hours following admission to services.)

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

United Quest Care Services, LLC

"Providing Effective Cultural & Competent Care"

CONSENT FOR RELEASE OF CLIENT INFORMATION

To Permit Use and Disclosure of Health Information

This authorization from implements the requirements for consumer 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.

Consumer:	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 Consumer/Guardian:	Date:
Witness:	Date:

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CONSENT FOR RELEASE OF CLIENT INFORMATION

To Permit Use and Disclosure of Health Information

This authorization from implements the requirements for consumer 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.

Consumer:	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_____

- 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 Consumer/Guardian:	Date:
Witness:	Date:

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"Providing Effective Cultural & Competent Care"

CONSENT FOR RELEASE OF CLIENT INFORMATION

To Permit Use and Disclosure of Health Information

This authorization from implements the requirements for consumer 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.

Consumer:	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_____

- 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 Consumer/Guardian:	Date:
Witness:	Date:

United Quest Care Services, LLC

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PSYCHOTROPIC MEDICATION INFORMED CONSENT

On the date noted below the physician has:

1. Proposed to the consumer named below, or his/her legal representative, all medications for the initial visit have been reviewed.
2. Discussed what the medication is for, how the medication works, the risk associated with the medication, the intended Benefits of using the medication, its side effects, contraindications, potential implications between medications and diets/exercise, risks associated with pregnancy, the importance of taking the medication as prescribed, the identification of potential obstacles to adherence, the need for laboratory monitoring, the rationale for each medication, early signs of relapse related to medication efficacy, signs of non-adherence to medication prescription, potential drug reactions when combining prescription and non-prescription medication, including alcohol, tobacco, caffeine, illicit drug, and alternative medications, instruction on self administration, wellness management and recovery planning, the availability of financial supports and resources to assist the persons with handling the costs associated with medications.
3. Discussed alternative treatments (including no treatment and its consequences)
4. Discussed the need for initial/periodic medical or laboratory tests/consultations, which if not undertaken could lead to the termination of treatment on safety grounds
5. Discussed the estimated duration of treatment with this medication(s)

RULES for Treatment:

1. Take medication exactly as prescribed. Do not increase the dose without checking with the doctor or nurse first.
2. Don't expect early refills. This is usually taken as a sign that your medication is being misused.
3. Replacement of stolen prescriptions will not be considered without a police report or at agency discretion. If your medication is reported stolen more than once you will be tapered off the medication and may be terminated. This also applies to lost medications.
4. If you refuse or fail an urine drug test you may be dismissed.
5. If you are receiving the same or similar medication from another doctor without informing us, you will be dismissed.
6. If we have reason to believe you are involved in illegal activities with your medication, you will be dismissed.
7. If you are using additional pharmacies to fill controlled drug prescriptions without informing us you will be tapered off the medications or be dismissed.
8. If you test positive for illegal drugs or are believed to abuse alcohol/drugs you will not be able to continue services if you do not obtain treatment with physician monitoring.
9. If a refill is due before your next appointment you will need to call us at least 2 days before the medication is going to run out.

I understand and consent to the administration of this medication(s) as ordered by the physician and agree to follow the regime and recommendations as prescribed, and of undertaking medical and laboratory tests when they are ordered by the physician as described above. I also agree while on this medication(s) to report any change in health to my physician or disclose if I am receiving any treatment for psychotropic or controlled medications. I received information regarding the benefits and side effects of the following medication(s):

Signature of Consumer/Guardian:	Date:
Consumer's Printed Name:	
Medical Provider:	Date:

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ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

United Quest Care Services, LLC prohibits the use of restrictive interventions (restraints, seclusion, time-out, use of protective devices). If a consumer requires some type of intervention due to threatening, escalating, aggressive, uncontrollable behaviors and/or actions, staff will attempt verbally to calm and redirect.

If this approach is not effective, staff will contact the consumer's legally responsible caretaker and/or law enforcement to intervene and terminate the behavior(s) or action(s) in which the consumer is in danger of abuse or injury to self or other persons or when substantial property damage is occurring.

If the consumer is an imminent threat of harm to staff, his/herself, or others, staff will immediately call 911 prior to contacting the legally responsible caretaker.

United Quest Care Services, LLC staff utilize and are trained in North Carolina Interventions (NCI).

By signing below, I acknowledge that I have been made aware of and thoroughly understand UQCS's intervention policy and agree to fully cooperate when called upon.

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

United Quest Care Services, LLC

"Providing Effective Cultural & Competent Care"

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 patients. 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 patient confidentiality, the regulations will require that you take a number of administrative measures to ensure that any patient-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 consumers 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 Consumer/Guardian: Date:
Consumer's Printed Name:

United Quest Care Services, LLC

"Providing Effective Cultural & Competent Care"

Patient 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 Consumer/Guardian: Date:
Consumer's Printed Name:

Notification of Receipt of Client Rights

I understand the contents regarding client rights and responsibilities. I have received a copy of the confidentiality notice, Client Handbook (which includes a summary of my rights), Appeals Steps Process and Flow Chart (Medicaid clients 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 client's rights.

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

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

United Quest Care Services, LLC

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How to Make a Compliant or File a Grievance

To all consumers of United Quest Care Services, LLC,

If you are dissatisfied with the services being provided by United Quest Care Services, LLC or if you wish to file a grievance against perceived unfair treatment, the follow procedures can be followed:

- Begin by explaining your concern, complaint, or grievance to the professional providing the service.
- The treating professional will attempt to resolve the problem by scheduling a meeting in order to come to a joint decision.
- If the meeting with the professional does not resolve the problem, put your concern/grievance in writing and ask for it to be reviewed in the Human Rights Committee for resolution.
- You may also contact the Area program responsible for referring you to our agency's Consumer Rights/Advocacy/Consumer Human Rights Committee. The Area Program also has the option of taking your grievance to their committee if you are not satisfied with the decisions of the Consumer's Rights Committee of United Quest Care Services, LLC
- You will be informed that the decision of that committee will exhaust the administrative appeal process. You will also be informed that at any time you feel legal advice is necessary, you can do so at your own expense or contact the following: Legal Services for Developmentally Disabled Persons, 325 North Salisbury St., Raleigh, NC at 919-834-7023 or the Governor's Advocacy Council at 800-832-6922
- Any person who provides care, treatment, or services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from UQCS.
- Any individual who provides care, treatment, or services should be free to raise concerns to The Joint Commission when UQCS has not adequately prevented or corrected problems that can have or have had a serious adverse impact on individuals served. To support this culture of safety, UQCS must communicate to staff that such reporting is permitted. Further, UQCS must make it clear to staff that no formal disciplinary actions (for example, demotions, reassignments, or change in working conditions or hours) or informal punitive actions (for example, harassment, isolation, or abuse) will be threatened or carried out in retaliation for reporting concerns to The Joint Commission.

Notification of NC Medicaid Consumer's Right to Appeal Acknowledgement Form

Medicaid Rights

Our job is to evaluate your treatment needs. Sometimes, evaluations show that a person who requests a specific service may not benefit from or qualify for those services. Sometimes evaluations show that a person who is receiving a service may no longer need the service.
When this clinical decision is made, we must inform you in writing. The letter contains:

1. The reason for our decision;
2. The laws that support your appeal rights; and
3. The appeal steps and deadlines.

What is a Medicaid Appeal?

You have the right to *disagree* with and appeal the decision to:

- Deny your request for services; and/or
- Reduce, suspend or terminate a service you are currently receiving.

You appeal the decision by following the federal and state laws to resolve the decision by following federal and state laws to resolve the disagreement.

I, _____ do hereby acknowledge that I have read the above statement regarding my right to an appeal, file a grievance, and that I may find more detailed information in my client's rights handbook that will be given to me upon Admission to services determined during my assessment. I furthermore acknowledge that if I have any questions concerning my rights, I can contact my Medicaid worker or a staff member of United Quest Care Services, LLC

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

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NOTICE OF CONFIDENTIALITY &INFORMED CONSENT

United Quest Care Services, LLC will maintain sufficient records to justify appropriate treatment. The information you give to us is confidential and release or disclosure of any identifiable information to any individual or agency is prohibited under the following ethical and legal conditions:

1. Client/legal representative has signed a valid authorization of release of information to a third party. (Informed Consent)
2. Client is seeking treatment at a facility within the North Carolina Division of Mental Health, DD, and Substance Abuse Services, and it has been determined to be in the client's best interest to disclose information to the facility where client is requesting services. (This excludes clients receiving substance abuse treatment.)
3. In the interest of public safety. (It is determined by a clinical staff member that the client presents a danger to self and/or others.)
4. In response to a court order by a judicial official.
5. In response to a medical emergency.
6. State and federal laws require reporting of child abuse, child neglect, gunshot/ knife wounds, and communicable diseases.
7. In cases where spouse/elder abuse or neglect is disclosed in the course of treatment, this information may be reported to local protective services agencies to include the Army Family Advocacy Program (pertains to beneficiaries).
8. Crimes committed at United Quest Care Services, LLC against an employee and any threat to commit such a crime.
9. In the investigation of life-threatening communications to an elected official.
10. The confidentiality of alcohol and drug abuse records maintained by this agency is protected by Federal Law and regulations. Any violation of Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Only authorized staff members have access to this data.

LIMITS ON CONFIDENTIALITY

We are required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your therapist was appointed by the courts to evaluate you.
4. Your contact with your therapist is for the purpose of determining your sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. The contact is one in which your psychotherapist must file a report to a public employer or as to disclose information required to be recorded in a public office, if such report is open to public inspection.
7. You are under the age of 16 years and are the victim of a crime.
8. You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.
9. You die and the communication is important to decide and issue concerning deed or conveyance, will or other writings executed involving you affecting as interest in property.
10. You file suit against your therapist for breech of duty or your therapist files suit against you.
11. You have filed suit against anyone and have claimed mental emotional damages as part of the suit. You waive your rights to privacy or give consent to limited disclosure by your therapist.
12. Your insurance company paying for services has the right to review all records.

I UNDERSTAND THE ABOVE STATEMENT THAT HAS BEEN READ AND EXPLAINED TO ME BY A MEMBER OF THE TREATMENT FACILITY STAFF, AND I HAVE RECEIVED A COPY OF THIS NOTICE.

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

United Quest Care Services, LLC

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Consumer Handbook Receipt of and Acknowledgement

Check all items that apply regarding the things that you have been oriented to concerning treatment and what can be expected from United Quest Care Services, LLC.

Orientation to Orientation
A team member informed me before the intake the process of Orientation and what to expect.
I received a Consumer Handbook and a copy of the Intake of all information that was explained to me.
Was given all contact information from the company including companies phone number, address, office hours and days of operation.

Timeline of services
Was explained scheduling of Assessments and assessments I can expect to receive.
Contacts from My Treatment Team were explained as well as when I can expect to hear from My Treatment Team after orientation.
Expected start date with treatment team member
Person Centered Treatment Plan information and how to receive a copy of PC Treatment Plan

Orientation to Privacy Practices
Informed on HIPAA regulations
Informed on Client Confidentiality and limits thereof
Informed on Clients rights
Informed on UQCS' Code of Ethics

Orientation to Crisis Response
Received all crisis call phone numbers
Was explained the process of making a crisis call
Was explained what to expect when in crisis and a crisis call is made

Orientation to nature of Services
The definition of the services provided was explained to me.
Was explained how the treatment is developed.
I was given an opportunity to ask questions about the service.
I was given satisfactory responses to all questions given.
UQCS' expectations of the client and family was explained
UQCS transition criteria and discharge criteria

Orientation to Complaints and Grievances
Explained how to make a compliant
Explained the process of making a grievance
Explained the follow up towards all complaints and grievances
Received information in intake on Grievance procedures

Orientation for the Premises
Explained where emergency exits are located
Explained where first aid kits and fire extinguishers are located

Orientation for the UQCS Program Rules
Informed on Weapon, Tobacco, Illegal, and Prescribed Drugs Policies
All attitudes, behaviors, & events that may lead to program dismissal

I have received a copy of the UQCS Consumer Handbook:

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

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AUTHORIZATION TO PAY/ FINANCIAL POLICY

Patient's Name:_____ DOB:_____

Responsible Party:_____Relationship to Patient:_____
DOB:_____

Insurance Company Name(1):_____ Subscriber Number:_____

Insurance Company Name(2):_____ Subscriber Number:_____

1. PAYMENT is expected at the time of your visit, unless prior arrangements have been made. We accept cash, checks, and credit cards.
2. INSURANCE CLAIMS – as a courtesy to our patients, we will fill your primary insurance policy. Please remember insurance coverage is a contract between the patient and the insurance company. We will expect the patient to be responsible for the payment in full. HMO, PPO, and MANAGED CARE – We belong to a number of managed care plans. It will be important that you check with your insurance company to verify whether you need authorization for psychiatric outpatient treatment services. The initial authorization must be obtained by the patient, otherwise you will be responsible for the payment. Upon initial authorization, you will be responsible for the co-payment. MEDICARE – This office accepts Medicare assignment. Mental Health is covered at 62.5%. You will be expected to pay your percentage of what Medicare does cover if you have met your deductible. You will be expected to pay in full if your deductible has not been met. MEDICARE & MEDICAID – Medicare and Medicaid do not cover Medicare approved psychiatric charges at 100%. Combined they pay 62.5% of the approved charges. The patient is responsible for the 37.5% co-payment.
3. NO INSURANCE – Patients that do not have insurance are expected to pay for treatment in full at the time of service.
4. MINOR CHILDREN – It is the responsibility of the accompanying parent to see that payment is made in full at the time of service.
5. CREDIT – We can arrange a monthly budget payment plan, if credit is determined to be necessary due to hospitalization a the agency's discretion. Patients who arrange credit and who have agreed to a monthly payment plan, are required to comply with all scheduled payments. A monthly re-billing fee will be charged if payment is not received within 30 days.
6. RETURNED CHECKS – A service fee of $35.00 will be applied to all returned checks. You will be asked to bring cash to our office to cover the amount of the check, plus the service charge.
7. ACCOUNTING PRINICPALS – Payments and credits will be applied to the oldest charges first, except for the insurance proceeds, which are applied to the charges for which received.
8. NO SHOW/CANCELLATION FEE – If you must cancel or reschedule your appointment, then you must do it 24 hours before your appointment time, or you will be charged a fee of $35.00. If you are a "NO SHOW" for your appointment, then the same fee of $35.00 will apply. (This fee is NOT covered by insurance companies)
9. I do understand that if is my responsibility to pay the account in. Insurance will be filed as a courtesy. I also understand that my insurance may, or may not, pay the charged incurred. I authorize payment of the medical benefits to the doctor, or supplier of services, named above for the services rendered.
10. This authorization shall remain valid for any services provided pursuant to the said arrangements. You agree that you are the responsible party on this account.
11. The patient is entitled to receive a copy of the authorization upon request. A photocopy of the signed form shall be as valid as the signed original. I authorize the release of any information to the insurance companies needed to process any claims, filed by this office, for the above named patient.

"I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THE FINANCIAL POLICY AND AUTHORIZATION TO PAY"

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

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PERSON CENTERED PLAN PARTICIPATION

I, _____ have met in person, video or by telephone with agency staff to review and discuss my concerns regarding the goals, outcomes represented in the treatment and crisis plan. The goals and clinical direction have met my expectations and I am in agreement with the direction of my services.

request to have anyone involved in my treatment at this time.

If you request others to be involved in Person Centered Planning, these boxes are REQUIRED:

Name	Phone or Address

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

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URINALYSIS CONSENT FORM

I hereby agree, upon a request made under the urinalysis policy of United Quest Care Services, LLC (company) to furnish a sample of my urine, breath, saliva, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination. I further authorize and give full permission to have the company and/or its company physician send the specimen or specimens so collected to a laboratory for a screening test for the medication and treatment compliance purposes under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the company and/or to any entities involved in connection to the test.

I understand that only duly-authorized Company officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make decisions related to treatment and to respond to inquiries or notices from government entities.

I will hold harmless the Company, its company physician, and any testing laboratory the company might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of services or any other kind of adverse action that might arise as a result of the testing, even if a Company or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless the Company, its company physician, and any testing laboratory the Company might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

Signature of Consumer/Guardian:	Date:
Consumer's Printed Name:	
Witness:	Date:

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Telemedicine Session: Patient/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 patient 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 patient 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 patient 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 patients, a parent or legal caregiver might be instructed to bring the patient 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(Patient)/Guardian:	Date:
Member(Patient)'s Name:	