INTAKE

Date of Application:			**Record #:**
ADULT	**CHILD**		
FIRST NAME: MIDDLE NAME			**HIGHEST GRADE COMPLETED:**
LAST NAME:			**SCHOOL CONTACT PERSON:**
ALSO KNOWN AS/NICKNAME			**Parent/Guardian**
ADDRESS:			**NAME:**
CITY/TOWN:			**ADDRESS:**
STATE/ZIP:			**CITY/TOWN:**
PHONE#: (WORK)			**STATE/ZIP:**
DATE OF BIRTH:			**PHONE #: (WORK)**
SOCIAL SECURITY #:			**Referral Source**
COUNTY OF RESIDENCE:			**ARE YOU A WORK FIRST REFERRAL YES NO**
MALE	**FEMALE**	**MARITAL STATUS**	**PREFERRED PHYSICIAN TO CONTACT IN CASE OF EMERGENCY:**
RACE: WHITE BLACK AMERICAN INDIAN/ALASKAN NATIVE ASIAN PACIFIC ISLANDER OTHER:			
SIGNATURE/DATE:			

InfiniCore Group LLC
3540 Toringdon Way Suite 200
Charlotte, NC 28277
530.408.6622
InfiniCoreGroup@gmail.com

Insurance/Billing Information

Type of Insurance:	**Policy# Verified**
Secondary Insurance:	**Policy# Verified**

Medical Information

Primary Care Physician:	**Phone:**
Address:	**City/State/Zip:**
Are you currently taking any medications? Yes No	**If so what medications?**
Date of last visit:	

Date Of Referral:	**Date Of Initial Contact:**	**Date of Visit:**

Staff Completing Assessment: _____

For Office Use ONLY:

Scheduled for Admissions Referred Out/Rejected

If not scheduled for admissions, why?

_____

_____

Assigned/ Referred to:

_____

Program Name/Assignment:

_____

Clinical Signature:_____

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APPLICATION FOR ADMISSION

Verification of Consumer Choice

Beneficiary name: _____ Client record number: _____

I have received information regarding services which I am eligible to receive. I have been informed of providers from whom I am eligible to receive services from. Based on this information, I have made an informed choice of services and providers. I, _____, in completing these forms I am selecting InfiniCore Group LL C. as my provider of choice for the following services

[X]

Clinical Diagnostic Assessment

[ ]

Medication Management

[X]

Individual, Family, and/or Group Psychotherapy

CONSENT FOR TREATMENT

Consent for Services:

I authorize InfiniCore Group L LC to provide care and treatment of services to me. This may include Outpatient therapy, In-clinic therapy, adaptive skill training, community integration, support counseling, behavior management, crisis intervention, medication management, etc.

Beneficiary Signature: _____ **Date:** _____

Parent/Guardian Signature:_____ **Date:** _____

Witness Signature:_____ **Date:** _____

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EMERGENCY CARE CONSENT

I,_____, give InfiniCore Group LLC. permission to obtain emergency care information. Every effort will be made to honor the individual/parent/guardian choice of physician/hospital/ dentist. However, should an emergency arise that requires immediate assistance, the InfiniCore Group LLC employee will either call for emergency assistance through 911 or transport the client to the nearest emergency room or urgent care center.

Beneficiary Signature: _____ **Date:** _____

Parent/Guardian Signature:_____ **Date:** _____

Witness Signature:_____ **Date:** _____

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DISCLOSURE TO RELEASE/EXCHANGE BENEFICIARY INFORMATION

I, _____, legally responsible person of _____, hereby authorize InfiniCore Group LLC. to release protected health information when necessary from the medical record of: _____

Last Name _____ First Name _____
(please print) (please print)

Date of Birth _____Client Record Number MedicaidID#_____
Social Security #_____

FOR THE PURPOSE OF: Treatment Coordination

This authorization is freely given to InfiniCore Group LLC. with the understanding that:

1. I may revoke the authorization at any time, except where information has been released. This authorization is valid for a one (1) year period from the date it is signed, or for less time if revoked, if noted below. The revocation must be in writing (form is available from Motivational Care).

2. All records, written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

3. A photocopy or fax of this authorization is as valid as this original.

4. InfiniCore Group L LC.its employees are hereby release from legal responsibility or liability for disclosure or the above information to the extent indicated and authorized herein.

5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining the Authorization.

6. Information use or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and is no longer protected.

7. I understand that the records released may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS) and treatment for or history of drug or alcohol abuse.

8. InfiniCore Group LLC. Consumer Rights Committee shall have access to my confidential consumer information.

____ Yes. I authorize InfiniCore Group LLC to re-disclose information that was generated by another agency separate from InfiniCore Group LLC

____No. I do not authorize InfiniCore Group LLC to re-disclose information that was generated by another agency separated from InfiniCore Group LLC

Beneficiary Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date: _____

Witness Signature:_____ Date: _____

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DISCLOSURE FOR RELEASE OF CLIENT INFORMATION

Beneficiary Name:		**Record #:**	
SS#:		**Date of Birth:**	

I_____ request and authorize the use and disclosure of protected health (beneficiary/legal representative) information between **SCHOOL**: _____ (name of agency/person/facility or program providing information) and InfiniCore Group LLC(name of agency/person/facility or program receiving information).

The information to be disclosed includes:

x	Reciprocal Exchange Permitted	x	School Records/IEPs
	Admission/Screening Assessment Information		Substance Abuse Information
	Discharge Information Disclosure Report		Accounting of Disclosure Report
x	Medication Report / Physicians Report		Service Notes
x	Psychological Testing		Service Plan
	Psychiatric Evaluation Information/ Diagnosis		HIV / AIDS Related

Purpose: Referral Court Proceedings Service Delivery Coordination of Services At Consumer's request Assessment & Evaluation Determination of Benefits
Other: _____

I understand that once disclosed pursuant to this Authorization, it is possible that I will not be protected by the federal medical privacy law and that it could be re-disclosed by the person or agency that receives it.

I understand that with certain expectations, I have the right to revoke this authorization at any time. I understand that this Authorization will expire in one year unless revoked before that time.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 this authorization is made freely, voluntarily and without coercion. I understand the health information indicated will be disclosed per my instructions.

This authorization form implements the requirements for Beneficiary authorization to use and disclose Health information protected by the Federal Health Privacy Law CFR parts 160 and 164; the Federal Confidentiality Law 42 CFR part 2, Disabilities, and Substance Abuse Services GS 122C.

Beneficiary Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date: _____

Witness Signature:_____ Date: _____

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Client Grievance Rights

If a client has grievances it is the policy of InfiniCore Group LL C. to review all grievances that are made by our consumers or families. InfiniCore Group LLC. has a grievance form that we encourage our consumers to use that we may have for our records. This will be quality information for Quality improvement and quality assurance procedures of the agency. If they chose to call in their grievance, InfiniCore Group LLC. Human resource department will complete the form for them while they are on the phone. Grievances may be made verbally or in writing at any time the beneficiary feels that they have a legitimate complaint.

It is the policy of InfiniCore Group LLC. that the procedure of reviewing a grievance will be explained to the person served in a manner that is understandable. Our procedures include time frames that are adequate for prompt consideration for the complaint, that result in timely decisions for the person served. At any time in the grievance process, a beneficiary has the right to take their grievance directly to an outside source. The action of filing a grievance will not result in retaliation from InfiniCore Group LLC. or barriers to service provided.

By signing below you agree to have read and understand the above grievance rights of you as a client of InfiniCore Group LLC.

Beneficiary Signature: _____ **Date:** _____

Parent/Guardian Signature:_____ **Date:** _____

Witness Signature:_____ **Date:** _____

Acknowledgement of Beneficiary Rights

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I, _____, hereby understand the following

It is the policy of InfiniCore Group L LC.to inform all consumers in our care of their rights and responsibilities. InfiniCore Grou p LLC.will review all information with each individual consumer and family, answer any questions they may have, and have a signed document affirming their full understanding of their rights and responsibilities. InfiniCore G roup LLC.will provide clients with a copy of their rights and responsibilities and explain the content to them upon admission, prior to the initiation of services.
By signing below I agree to have received a copy of my beneficiary rights and fully understand its content.

_____

Beneficiary Signature Date

_____

Parent/Guardian Date

_____

Witness. Date

HIPAA Rights & Acknowledgement

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InfiniCore Group LLCagrees to comply with all Confidentiality and HIPAA Rules and Requirements in accordance with Federal and South Carolina laws and regulations, by virtue of the contractual agreement with RSII and the completion of this confidentiality form.

Confidentiality information includes, but is not limited to: photographs, videotapes, audiotapes, client records, reimbursements and information stored in automated files and clinical staff members and client files.

Individuals employed by InfiniCore Group LLCare subject to suspension, termination, or disciplinary action for the failure to comply with our policy concerning subchapter 1 8D Confidentiality Rules.

Violation of federal regulations is a crime punishable by a fine of not more than five hundred dollars ($500.00) for the first offense and not more than five thousand ($5,000.00) for each subsequent offence.

Individuals, other than employees but not including students and volunteers who fail to comply with the rules in this subchapter shall be denied access to confidential information by InfiniCore Group LLC. By signing below you agree to have read and understand the above HIPAA Rights and acknowledgement of InfiniCore Group LLC.

Beneficiary Signature: _____ **Date:** _____

Parent/Guardian Signature:_____ **Date:** _____

Witness Signature:_____ **Date:** _____