WEST CARE

UPLIFTING THE HUMAN SPIRIT

GUIDANCE/CARE CENTER, INC.

3/4/2021

Thank you for choosing the Guidance/Care Center, Inc. To make this process easier we have compiled these documents to review and complete prior to your appointment.

Please read, fill out, and sign consents for services as best as you can. GCC staff will review the paperwork with you at the time of intake.

Please DO NOT DATE the paperwork. Please do not have anyone sign as a witness. This will be completed at time of the appointment.

Thank you

1205 4th Street
Key West, FL 33040
Telephone: 305.434-7660
Fax: 305.292-6723

3000 41st Street, Ocean
Marathon, FL 33050
Telephone: 305.434.7660
Fax: 305.434.9040

99198 Overseas Hwy, Suite 5
Key Largo, FL 33037
Telephone: 305.434.7660
Fax: 305.451.8019

Partially funded by the Florida Department of Children and Families
and Monroe County

CLIENT INFORMATION

Today's Date: _____ **Client #** _____

Last Name: _____ **First:** _____ **M:** ___

Address: _____ **Apt #**_____

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

Home # ( ) _____ **Cell #** ( ) _____
S.S #_____ **DOB:** _____ **Age:** _____
Email: _____
Marital Status: Single, Never Married ( ) Divorced ( ) Legally Separated ( ) Married ( )
Living w/Significant Other ( ) Widowed ( ) Registered Domestic Partner ( ) Unreported ( )

Gender: Female ( ) Male ( ) Transgender Female ( ) Transgender Male ( ) Other ( )

Please check one of the following for Race and Ethnicity.
Race: White ( ) Black ( ) America Indian ( ) Asian ( ) Native Hawaiian ( ) Other Pacific Islander ( ) Multi-racial ( )

Ethnicity: Puerto Rican ( ) Mexican ( ) Cuban ( ) Other Hispanic ( ) Haitian ( ) None ( )

Sexual Orientation:
Straight/Heterosexual ( ) Gay Male ( ) MSM ( ) Lesbian ( ) Bisexual ( ) Pansexual ( ) Asexual ( )
Refuse to Answer ( ) Other ( )

Do you work?:_____ **If not, why?** _____

Employer: _____ **Work #** _____

Emergency contact: _____ **Relationship**: _____

Address: _____ **State:** _____ **Zip:** _____

_____

If this is a child, please list one parent's name and work phone # who will be the primary contact?
Name: _____ **Work #:** _____

_____

Please complete the following, as this information will help us serve you better.
How were you referred to us?_____
Who will be responsible for the payment of these services?:_____
Do you have Medicaid? _____
Do you have Insurance?_____ Who is the policy holder of the Insurance?_____
Name:_____ Soc Sec #:_____ DOB:___/___/____
Are you coming here voluntary ( ) or involuntary ( ) (court ordered, probation, job, etc)
Have you been here before? _____ If so when? _____
Do you need to provide us with any other information in order to serve you?

_____

state form

GCC
Client Register

Clients Name: _____ **DOB:**_____**Client #:**_____

Marital Status: _____

1-Single	5-Seperated
2-Married	6-Unreported
3-Widowed	7-Registered Domestic Partner
4-Divorced	8-Legally Separated

Nationality:_____

Examples but certainly not limited to:
American, Brazilian, Chilean, Columbia, Cuban, Dutch, French, German, Haitian, Honduran, Korean, Mexican, Pole, Puerto Rican, South African

Country/Region of Birth: _____

Examples but certainly not limited to:
Argentina, Australia, Canada, Columbia, Cuba, Czech Republic, Hatti, Mexico, Sweden, United Kingdom, United States

Highest Education Completed: _____

20-No Schooling	28-High School Graduate, Diploma or Degree
21-Nursery Schooling to 4th Grade	29- 1 or more Year College, No Degree
22- 5th to 6th Grade	30-Associate's Degree (AA, AS, etc.)
23- 7th to 8th Grade	31-Bachelor's Degree (BA, BS, AB, etc.)
24- 9th Grade	32-Master's Degree (MS, MA, MSW, etc.)
25-10th Grade	33-Prof. Degree (MD, DDS, JD, etc.)
26-11th Grade	34-Doc. Degree (PhD, EDD, etc.)
27-12th Grade	35-Special School
36-VocationalSchool	36-Vocational School

Veteran Status: _____ 0-NO _____1-YES

Employment Status: _____

10- Active military, overseas	70-Terminated/Unemployed
20- Active military, USA	81-Homemaker
30- Full Time	82-Student
40- Part Time	83-Disabled
50- Leave of Absence	84-Criminal inmate
60-Retired	85-Other inmate (psychiatric institution)

Primary Source of Income: _____

1-Salary	4-Disablity	7-Unknown
2-Wages/TANF	5-Other	
3-Retirement/Pension/SSI	6-None	

*** Personal Income: __ __Client's annual personal (gross) income of the client's total earnings for the year in thousands**

*** Family Income: __ __ Client's annual family (gross) income of the client's household in thousands**

*** # Of Dependents under 17 years: _____**

*** Family Size: _____ Number of persons that are living in the house**

TANF Status: 3

30.*Developmental Disabilities: ___ 33.*Visually Impaired: ___
31.*Physically impaired: ___ 34.*Hearing impaired:___
32.*Ambulatory: ___ 35.* English language severely limited: ___

Legal Guardian: _____

1. Parent
2. Other relative
3. Non relative
4. Emancipated minor
5. State public agency
6. Not applicable

GUIDANCE/CARE CENTER, INC.
Client Financial Information Form and
Sliding Fee Scale Application

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

Financial Coverage (client to initial each line and Indicate coverage below):

_____ Medicaid Coverage No _____ Yes: ID#: _____ Plan: _____

_____ Medicare Coverage No _____ Yes: ID#: _____ Plan: _____

_____ Insurance Coverage No _____ Yes: ID#: _____ Plan: _____

Sliding Fee Scale (client to initial and complete applicable section)

_____ **I do not wish to apply for the Sliding Fee Scale at this time. I understand that I will be responsible for paying full fee at time of service.**

_____ **I wish to apply for the Sliding Fee Scale for any services not covered by any payer or payers noted above. I agree to provide proof of income and I give permission to the Guidance/ Care Center, Inc to obtain a copy of my Federal Tax return, if necessary. I agree to pay for services received. I agree to inform the Guidance/ Care Center, Inc. if my financial situation changes. An individual's failure to make payment under a provider's sliding fee scale shall not prevent the individual from receiving services and we will assist you in developing a payment plan.**

Family Income = $_____ per year # of persons supported by this income = _____

I certify that the above information is true and accurate to the best of my knowledge. I understand that, in accordance with the Florida Statutes 81750, providing false information to defraud a health care provider for the purposes of obtaining goods or services is a misdemeanor in the second degree and is punishable by law.

Client signature: _____ Print Name: _____ Date: _____

GCC witness signature: _____ Print name: _____ Date: _____

For GCC use only Client ID: _____

Fund Source _____ eligibility record created on: _____ by: _____

Fund Source _____ eligibility record created on: _____ by: _____

Fund Source _____ eligibility record created on: _____ by: _____

Fund Source _____ eligibility record created on: _____ by: _____

Fund Source _____ eligibility record created on: _____ by: _____

Sliding Fee Discount % _____

WESTCARE

UPLIFTING THE HUMAN SPIRIT

GUIDANCE/CARE CENTER, INC.

CLIENT NAME:_____ CLIENT #:_____

SLIDING FEE SCALE

G/CC offers a sliding fee scale to assist in the associated costs of providing services. In order to assess a discounted payment for the services you are receiving you are required to provide G/CC with documentation supporting your request for a discounted fee. Proof of income may include:

- Copy of Bank Statement
- Copy of most recent taxes
- Copy of pay stub
- Food Stamp/SSI verification

- For persons stating they do not work and/or do not receive any other financial assistance, can submit a letter from the person supporting you stating same.

One of these must be provided in order to be assessed for the discounted sliding fee scale. If proof of income is not received, the full fee will be assessed and billed to your account. An individual's failure to make payment under a provider's sliding fee scale shall not prevent the individual from receiving services. We are happy to assist you in developing a payment plan. Certificates of completion for court ordered or other mandated treatment (DUI Advocate, Department of Corrections or Drug Court) will not be supplied until the balance is paid in full.

G/CC understands the high cost of living in our community and wants to help you. Please help us to help you and supply the needed documentation so we can!

Thank you!

FINANCIAL

Upper Keys
99198 Overseas Hwy., Suite 5
Key Largo, FL 33037
(305) 434-7660 phone
(305) 451-8019 fax

Middle Keys
3000 41st Street, Ocean
Marathon, FL 33050
(305) 434-7660 phone
(305) 434-9040 fax

Lower Keys
1205 Fourth Street
Key West, FL 33040
(305) 434-7660 phone
(305) 292-6723 fax

www.guidancecarecenter.com

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Phone: 305-434-7660
Fax: 305-451-8019

1205 Fourth Street
Key West, FL 33040
Phone: 305-434-7660
Fax: 305-292-6723

Client Name: _____ DOB:_____Client#:_____

Assignment of Benefits / Release of Medical Information

I hereby authorize and request that payment of benefits by my Insurance Company(s) _____, be made directly to Guidance/Care Center, Inc.., herein referred to as "**GCC**", for services furnished to me or my dependent. I understand that my Insurance Company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize GCC to disclose any and all written information from the above named to my above named Insurance Company and/or its designated representatives, or other financially responsible party, at the determination of GCC. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release GCC its officers, agents, employees and any clinician associated with my case, from all liability that may arise as a result of disclosure of information to the above named Insurance Company(s) or their designated representatives.

By signing this Assignment of Benefits and Release of Information, I acknowledge:

- I am aware and understand that this authorization will not be used unless the above-named Insurance Company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
- I agree to participate and assist GCC its designated representatives with any appeal process necessary to collect payment for the services rendered. An individual's failure to make payment under a provider's sliding fee scale shall not prevent the individual from receiving services. We are happy to assist you in developing a payment plan.
- I am aware and have been advised of the provisions of Federal and State Statutes, rules and regulations that provide for my right to confidentiality of these records.
- I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
- GCC is acting in filing for insurance benefits assigned to GCC and it can assume no responsibility for guaranteeing payment of any charges from the Insurance Company(s).
- Billing may be done by a firm contracted by GCC for billing and collection purposes.
- GCC has been appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier.
- Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
- GCC shall be entitled to the full amount of its charges without offset.
- I agree to endorse and forward to GCC any monies from the Insurance Company paid to me and/or the primary insured. I understand that I am otherwise responsible for the cost of any and all charges accrued.

I acknowledge receipt of a completed and signed copy of this assignment and release form:

_____ Client Signature

_____ ☐Legal Guardian or ☐Insured Policyholder

_____ Print Client Name

_____ Print Name

_____ Witness Signature

_____ Date of Signatures

_____ Print Witness Signature

FINANCIAL

Guidance/Care Center, Inc.

Client Name: _____ **DOB:**_____ **Client#:** _____

FINANCIAL AGREEMENT

In compliance with commercial insurance regulations, arrangement for payment of co-payments and deductibles will be made at the time of admission. Please be advised that we bill your insurance company as a courtesy to you. Any remaining balances are your Responsibility.

The following constitutes the financial policy of Guidance/Care Center, Inc., hereafter called "facility", with respect to services rendered at this facility.

1. Facility charges for Outpatient services are based on fee for service schedule.
2. Facility charges are an all inclusive per diem rate of $650.00 for CSU, $600.00 for Detox.
3. Facility may bill insurance carriers on behalf of the Client where applicable. This is a service we provide for our Clients. The Client is still responsible for all charges incurred.
4. Facility has contractual agreements with some insurance carriers. Some contracts require that we accept payment from the insurance carrier as payment in full. In such cases clients may not be responsible for co-payments and deductibles.
5. If insurance carrier fails to remit payment for services within ninety days, the Client will be billed for the balance on the account. All statements are due in full upon receipt.
6. Facility does not provide refunds of any moneys paid by or on the behalf of Client when the Client leaves the facility against medical advice or for major rule violations.
7. If Client is transferred for therapeutic or medical reasons, any moneys paid by or on behalf of the Client will be refunded less our full per diem rate for each day Client was at our facility.
8. Initial payment for treatment is due upon admission unless insurance assignments are accepted. Subsequent payments are due on the first day of each subsequent treatment period.
9. I understand that my records are protected under Federal Confidentiality regulations (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations) published August 10, 1987, and cannot be disclosed without my written consent unless other provided in the regualations. I understand that my medical record may contain information concerning my psychiatric, psycholgical, drug or alcohol abuse, HIV/AIDS and/or related conditions.

_____ _____

Client Signature Date

_____

Print Client's Name

_____ _____

Witness Signature Date

_____

Print Witness's Name

FINANCIAL

GUIDANCE/CARE CENTER, INC.
Insurance Verification Form

Client ID:	Location

To be completed by the client

Client's Name:			**Phone #**	
Date of Birth:	**S.S. #**		**Cell #**	
Address:	**City:**		**State:**	**Zip:**
Insured Name:			**Relation:**	
Date of Birth:	**S.S. #**		**Phone #**	
Insured Employer:			**Phone #**	
Insurance Company:			**Phone #**	
ID/Policy #			**Group #**	

TAX ID : 59-145-8324 **Main NPI: 1184627739** **Medicare Provider #77517**

To be completed by the business office

Date:	Time:	Insurance Representative:	
Effective Date:	In Network (?) Yes_____ No _____		

Mental Health Benefits

Pre-Cert Needed: Yes ___ No ___ Deductible $_____ Deductible Met $_____ Lifetime Max: $_____			
Co-Payment (Office Visit)	Out of Pocket Max.:	Days (Sessions) per Yr.:	Days (Sessions) used.:

Substance Abuse Benefits

Pre-Cert Needed: Yes ___ No ___ Deductible $_____ Deductible Met $_____ Lifetime Max: $_____			
Co-Payment (Office Visit)	Out of Pocket Max.:	Days (Sessions) per Yr.:	Days (Sessions) used.:

Billing Address:	**City:**	**State:**	**Zip:**

Verified By: Date	Policy Exclusions:
Entered into WC CDS by: Date	

\\westcare.local\files\FL-GCC\Finance\Clients Billing\Finacial forms for Intake\Insurance Verification GCC eff 03-2014 Rev 03-2014

FINANCIAL

GUIDANCE / CARE CENTER, INC.

CERTIFICATION OF ELIGIBILITY FOR **PATH** SERVICES

Client name: _____ DOB: _____ Client ID#: _____

Guidance Care Center collects information from our clients about their current / recent involvement with homelessness. This allows us to better determine any special needs our clients may have so that we may appropriately refer to programs and services that are the most beneficial.

Have you been homeless (anywhere) in the past year? ☐ YES ☐ NO

Are you currently homeless or at risk of being homeless? ☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY

	Homeless with last 30 days
	Homeless 31-60 days
	Homeless 3-6 months
	Homeless up to a year
	At risk of losing housing
	Challenges to housing include mental health/substance use or other behavioral issue

To the best of my ability, I have provided accurate information related to my current situation:

_____

Client Signature Client Printed Name Date

A response of "YES" to either question above is a qualifying response. I have reviewed the information provided and determined that this client

☐ is ☐ Is not eligible for PATH services.

_____

Staff Signature / credentials Staff Printed Name Date

**********FOR OFFICE USE ONLY**********

PATH (TBD) eligibility record created on:_____ by:_____

Primary Fund Source: _____

Secondary Fund Source (if applicable): _____

FINANCIAL

GUIDANCE / CARE CENTER, INC.

CERTIFICATION OF ELIGIBILITY FOR FORENSIC MENTAL HEALTH SERVICES

Client name: _____ DOB: _____ Client ID#: _____

Guidance Care Center collects information from our clients about their current / recent involvement with the Criminal Justice system. This allows us to better determine any special needs our clients may have so that we may appropriately refer to programs and services that are the most beneficial.

Have you been arrested (anywhere) in the past year? ☐ YES ☐ NO

Date of most recent arrest: _____

Are you currently involved with the criminal justice system? ☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY

	Currently on Probation
	Currently on Parole
	Adjudicated ITP (Incompetent to Proceed)
	Adjudicated NGI (Not Guilty by reason of Insanity)
	Other:

To the best of my ability, I have provided accurate information related to my forensic involvement

_____

Client Signature Client Printed Name Date

A response of "YES" to either question above is a qualifying response. I have reviewed the information provided and determined that this client

☐ is ☐ Is not eligible for forensic services.

_____

Staff Signature / credentials Staff Printed Name Date

**********FOR OFFICE USE ONLY**********

Forensic FS (15) eligibility record created on: _____ by: _____

Primary Fund Source: _____

Secondary Fund Source (if applicable): _____

FINANCIAL

Guidance/Care Center, Inc.

ACKNOWLEDGEMENT OF UNDERSTANDING OF GRIEVANCE PROCESS

CLIENT NAME: _____ **CLIENT #:** _____

As a client, parent, and/or legal guardian of a client, participating in one of Guidance/Care Center, Inc. treatment programs you have the right to file a complaint through the following grievance procedure without fear of discharge or reprisal and free from interference, coercion, or discriminations.

Legal Custody: In the event a grievance involves a client who is in legal custody of another agency while in treatment at WestCare/ Guidance/Care Center, Inc., a representative(s) of that agency may be involved at any step.

Client Advocate: During the grievance process, if the client desires, a client advocate may assist him/her with understanding and going through the process of filing the grievance. The client advocate may be a case manager, a direct care staff member or any one connected with the client such as a family member, friend, and/or significant other.

Your rights as someone receiving Substance Abuse services are guaranteed protection by Florida Statute 397.501. The Florida Statute clearly describes these rights. You can access the Florida Statute at http://www.flsenate.gov/Laws/Statutes/2011/397.501. The Guidance/Care Center, Inc. also posts a copy of this law on its bulletin boards.

The grievance process is as follows:

a. Initially, the person served who filed the grievance and appropriate staff will meet to discuss the concerns of the person served and determine if a reasonable compromise or understanding can be reached. This step can include support staff and the Program Manager, Clinical Coordinator and/or Program Director as needed.

b. All Grievances submitted under this Policy shall be submitted in writing on the Feedback, Comment, Suggestions and Complaints form (attached) and pursuant to all established guidelines and processes as set by the Chief Clinical Officer.

c. A person served may elect to have an advocate assist them with understanding and going through the process of filing a grievance. The advocate of the person served may be a case manager, a direct care staff member or anyone connected with the person served such as a family member, friend, and/or significant other.

d. In the event a Grievance involves a person served who is in the legal custody of another collaborating agency while the person served is also receiving services at WestCare, representative(s) of that collaborating agency will be involved throughout the process, if state regulations require this action.

e. All Grievances shall be responded to, in writing, by the Program Director within ten (10) business days of receipt.

f. If the Grievance is not resolved within thirty (30) days, the Clinical Department will document the reason the grievance has not been resolved on the Feedback, Comment, Suggestions and Complaints form and include the plan for resolution.

g. Persons served shall be free of interference, coercion, discrimination or reprisal when filing a Grievance and free from retaliation or negative consequences as a result thereof.

h. A person served shall have the right to appeal any decision relating to their Grievance to the Regional Vice President within five (5) days of the finding. A date for the appeal will be set by the Regional Vice President but shall not be more than ten (10) business days after the date the person served submits the appeal. The Regional Vice President will submit a final written decision on the grievance within ten (10) business days of the appeal hearing. All subsequent appeals shall be made, if any, to the Chief Clinical Officer. The Chief Clinical Officer shall set the date for the final appeal within thirty (30) days of the notice of appeal from the person served and shall submit a final written decision within ten (10) business days of the hearing. The Chief Clinical Officer's findings shall be final and binding.

External Review Agency Contact Information:

Each program site shall display posters in an open area with contact information that includes the name, address, phone number of the external review entities for the region.

State of Florida, Department of Children & Families
District Alcohol, Drug Abuse, and Mental Health Program Office
401 NW 2nd Avenue
Miami, FL 33128
305-377-5029

Thriving Mind South Florida (formerly South Florida Behavioral Health Network)
7205 NW 19th
Suite #200
Miami, FL 33126
Phone: (305) 858-3335
Consumer Hotline: 1 (888) 248-3111

Abuse Hotline (1-800-96-ABUSE) or (1-800-962-2873)
Department of Children and Families website at: http://www.state.fl.us/cf_web/
Click on the icon titled "Report Abuse Online".

Council on Accreditation of Rehabilitation Facilities (CARF)
6951 East Southpoint Road
Tucson, AZ 85756-9407

CLIENT NAME: _____ **CLIENT #:** _____

http://www.carf.org/contact-us/
feedback@carf.org

A TTY number also is available for anyone with a hearing or speech impairment to report cases of alleged abuse at 1-800-955-8771.

CLIENT ACKNOWLEDGMENT

I read and understand the above grievance process. The Guidance/Care Center, Inc. also provided me a copy.

_____ _____
Client Signature Date

_____
Print Client's Name

_____ _____
Staff Signature Date

_____
Print Staff's Name

PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION AND/OR CONSENT FOR DISCLOSURE OF BEHAVIORAL HEALTH INFORMATION

PLEASE READ THE ENTIRE FORM, **ALL SIX PAGES**, BEFORE SIGNING BELOW

Person whose health information is being disclosed:

Name (First Middle Last): _____ Date of Birth (mm/dd/yyyy): _____

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

You may use this form to allow South Florida Behavioral Health Network (SFBHN) to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, you are voluntarily giving your authorization and/or consent ("Consent") to allow the use and disclosure (including paper, oral, and electronic sharing):

OF WHAT: ALL MY HEALTH INFORMATION, including information about sensitive conditions (if any).
This includes health information created before or after the date I signed this form. Health information includes, but is not limited to, my demographic information (name, address, date of birth, Social Security Number, race/ethnicity), and location of intake, treatment site and case management. It includes all records and other information regarding my health history, treatment, hospitalization, tests, residential and outpatient care, including medical history, physical exams and test results. This also includes my specific Consent to release any and all of the following information:

a. Drug, alcohol, or substance abuse;
b. Psychological, psychiatric or other mental impairment(s), mental condition or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501);
c. Sickle cell anemia;
d. Birth control and family planning;
e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis;
f. Genetic (inherited) diseases or tests.

Additionally, Medicaid eligibility information may be shared with SFBHN.

FROM WHOM: All information sources.
This includes, but is not limited to, medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and Veterans Affairs health care facilities, state registries and other state programs, social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, the Florida Department of Children and Families, state Medicaid, Medicare and any other governmental program.

TO WHOM: (please check one)
NOTE: Your basic demographic information (name, address, year of birth, and last four digits of social security number) may still be shared with network providers, SFBHN and its business associates, service providers, and payors listed in Attachment I to facilitate SFBHN operations. It will also be visible in the consumer search screen.

☐ **SFBHN its payors, trusted business associates, and service providers and ALL participating Network Providers of South Florida Behavioral Health Network listed in Attachment I & ALL Law Enforcement Partners listed in Attachment II.**

☐ **SFBHN its payors, trusted business associates, and service providers and ALL participating Network Providers of South Florida Behavioral Health Network listed in Attachment I.**

☐ **ONLY SFBHN and my current SFBHN treating Provider.**

Current Treating Provider Name: _____ Phone: (_____)

Address: _____ Fax: (_____)

☐

CONSENTS

☐ **SFBHN, my current SFBHN treating Provider, AND the specific organization(s) permitted to receive my information as listed below.**

Current Treating Provider Name:_____ Phone: (_____)

Address:_____ Fax: (_____)

Person/Organization Name:_____ Phone: (_____)

Address:_____ Fax: (_____)

Person/Organization Name:_____ Phone: (_____)

Address:_____ Fax: (_____)

Person/Organization Name:_____ Phone: (_____)

Address:_____ Fax: (_____)

Please use the back of the form to identify additional providers.

PURPOSE: To allow access to your information necessary to carry out the following activities (see page 4 of this form for more information):

- To provide you with medical treatment
- To obtain payment for your care
- For health care operations purposes, including disclosures to business associates
- To provide you with treatment-related services and products
- To make it easier to coordinate your care and schedule follow up services
- To evaluate and improve patient safety and the quality of medical care provided to all patients
- To create de-identified information to be used for any lawful purpose
- To create limited data sets to be used for research, public health, or health care operations
- To create aggregated data reports for group statistical research and analysis. The research and analysis will not contain any information that could be used to contact or identify you

Note: If you have not allowed full access to your information:

1. You may not be able to receive certain care coordination services, which require the sharing of your information; and
2. Your demographic information will still be shared with SFBHN and its business associates, service providers and payors. Your basic demographic information will also be visible in the consumer search screen.

EFFECTIVE PERIOD: **This Consent form will remain in effect until the day you withdraw your Consent, or upon two years following the completion of the treatment episode as indicated by the last entry in the chart, whichever is sooner.**

REVOKING YOUR CONSENT: Your Consent can be revoked at any time except to the extent that the organization which is to make the disclosure, has already taken action in reliance on it. You can revoke your Consent at any time by giving written notice to the person or organization to which you originally gave this form.

EFFECT OF REVOCATION OR EXPIRATION: Even if your Consent expires or is withdrawn, you will still be able to receive services from SFBHN. Revocation or expiration of your Consent will not affect actions taken while your Consent was in effect. If your information can no longer be shared, it will affect your ability to take full advantage of care coordination services provided by SFBHN.

AGREEMENT:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be disclosed to other parties, like SFBHN's business associates, service providers and payors, and other network providers (see page 4 for details).
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or consent.**
- **I have read all pages of this form and agree to the disclosures specified above from the sources listed.**

X _____ _____

Signature of Patient — Date Signed (mm/dd/yyyy)

X _____ _____

Signature of Patient's Legal Representative (if applicable) — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Legal Guardian
- ☐ Other personal representative (explain: _____)

You are entitled to get a copy of this form.

Explanation of "Patient Authorization Form for Full Disclosure of Health Information and/or Consent for Disclosure of Behavioral Health Information"

PLEASE READ AND INITIAL THIS PAGE BELOW

Laws and regulations require that some sources of personal information have a signed Consent form before releasing it. In addition, some laws require specific Consent for the release of information about certain conditions.

Why Your Information is Used and Disclosed: The South Florida Behavioral Health Network (SFBHN) works with the Florida Department of Children and Families to administer and manage a coordinated system of care for adults and children. The SFBHN Providers need to exchange information with each other to better manage your care. Trusted business associates and service providers of SFBHN are working to develop ways to better coordinate care and to improve quality and outcomes. As part of its efforts, these trusted business associates and service providers have developed utilization management software that is used by SFBHN and the Providers in its network. The business associates and service providers use and analyze de-identified information from that system for statistical research and analysis. Anything that identifies you will be removed from the information. This de-identified information will also be used by the trusted business associates and service providers to develop new commercial products.

Definitions: In this form, the term "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR §§ 160.103 and 164.501).

"To Whom":

- If you specified a healthcare provider in the "TO WHOM" section above, this Consent would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates, subcontractors or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified.
- If you specified an organization other than a healthcare provider in the "TO WHOM" section above, this Consent would also include that organization's staff or agents, business associates and subcontractors who carry out activities and purpose(s) permitted by this form for that organization that you specified.

Revocation: You have the right to revoke this Consent at any time regarding future uses by giving written notice. You should understand that organizations that had your Consent to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

Re-disclosure of Information: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources.

_____

Initials

Attachment I

South Florida Behavioral Health Network Providers

Banyan Health Systems, Inc.
Behavioral Science Research Institute, Inc.
Better Way of Miami, Inc.
Camillus House, Inc.
Care Resource Community Health Centers, Inc. (d.b.a.) CARE Resource
Catholic Charities of The Archdiocese of Miami, Inc.
Citrus Health Network, Inc.
Community Health of South Florida Inc. (CHI)
Concept Health Systems, Inc.
Douglas Gardens Community Mental Health Center of Miami Beach, Inc.
Family & Children Faith Coalition, Inc. d/b/a Hope for Miami
Federation of Families/ Miami-Dade Chapter, Inc.
Fresh Start of Miami-Dade, Inc.
Gang Alternative, Inc.
Guidance Care Center, Inc. (GCC)
Here's Help, Inc.
Institute for Child and Family Health, Inc. (ICFH)
Jessie Trice Community Health System, Inc.
Jewish Community Services of South Florida
Key West HMA LLC (d.b.a.) Lower Keys Medical Center
MDC-Community Action and Human Services Dept. (MDC-CAHSD)
Miami-Dade County Juvenile Services Department (MD-JSD)
Miami-Dade Homeless Trust (MDHT)
Monroe County Coalition, Inc.
New Hope CORPS, Inc.
New Hope Drop-In Center, Inc.
New Horizons Community Mental Health Center, Inc.
Passageway Residence of Dade County, Inc.
Psychosocial Rehabilitation Center, Inc., d.b.a, Fellowship House
Public Health Trust of Miami-Dade County, Florida (PHT) Jackson Health System Jackson Community Mental Health Center
South Florida Jail Ministries, Inc. (d.b.a.) Agape Family Ministries
The Center for Family and Child Enrichment, Inc. (CFCE)
The Key Clubhouse of South Florida, Inc.
The Miami Coalition For a Safe and Drug-Free Community, Inc.
The Village South, Inc.
Volunteers of America of Florida, Inc.

NOTE: SFBHN's payors include the State of Florida, including but not limited to, the Florida Department of Children and Families and the Florida Medicaid Program, and the federal government, including but not limited to, the Substance Abuse and Mental Health Services Administration.

Attachment II

South Florida Behavioral Health Law Enforcement Partners

Aventura Police
Bal Harbour Police
Biscayne Park Police
City of Miami Police
Coral Gables Police
Doral Police
FIU Police
Hialeah Police
Homestead Police
Hialeah Gardens Police
Key Biscayne Police
Medley Police
Miami Beach Police
Miami Gardens Police
Miami Shores Police
Miami-Dade County School Police
Miami-Dade Police
Miami Springs Police
North Bay Village Police
North Miami Police
North Miami Beach Police
Florida City Police
Opa-Locka Police
Pinecrest Police
South Miami Police
Sunny Isles Beach Police
Surfside Police
Sweetwater Police
FBI
ATF
University of Miami Police
US Department of Veteran Affairs Police
United States Postal Police
United States Secret Service
Virginia Gardens Police
West Miami Police
Florida Highway Patrol
FDLE
Monroe Sherriff Office
Key West Police

Guidance/Care Center, Inc.
CLIENT BILL OF RIGHTS - OUTPATIENT

1. You have the right to **Individual Dignity** at all times and during all occasions.
2. You have the right to retain your **Constitutional Rights** while in treatment.
3. You have the right to **Nondiscriminatory Services.** The Village cannot deny you admission to or participation in services based solely on:
   a. Your race, gender, ethnicity, age, sexual preference, HIV status, prior service departures against medical advice, disability, or number of relapse episodes.
   b. You taking medication prescribed by a physician.
   c. Your ability to pay for services.
4. You have the right to **participate** in the formulation and periodic review of your Wellness & Recovery Plan.
5. You have the right to receive care in the **least restrictive** environment based on your needs, what is in your best interests, and what is consistent with optimum care for you.
6. You have the right to participate in activities that **enhance your self-esteem.**
7. You have the right to **Quality Services**, more specifically, services suited to your needs delivered skillfully, safely, humanely, with full respect for your dignity and personal integrity, and in accordance with all statutory and regulatory requirements.
8. You have the right to **Communication.** You have the right to communicate by mail, telegram, phone and other forms of private communication as is consistent with an effective treatment program. The Village may make reasonable restrictions regarding the use of telephone, mail, and visitation rights, giving primary consideration to the well-being and safety of individuals, staff, and the community. The Village may monitor, open, or review any communication.
9. You have the right to the **Confidentiality of your Clinical Record** in accordance with Florida Statute 397.501 and applicable federal confidentiality regulations.
10. You have the right to representation by **Counsel** in an involuntary court proceeding.
11. You have the right to be informed in writing and prior to entering the program of any sanction, disciplinary measure, and modification of rights.
12. You have the right to receive information in writing and prior to entering the program of all existing rules and regulations.
13. You have the right to register complaints about the administration of rules, regulations, sanctions, disciplinary measures, and modifications of rights through a grievance procedure approved by the agency's Board of Directors.
14. You have the right to examine your records within the guidelines approved by the agency's Board of Directors, and to rebut any information in the record by inserting a counterstatement of clarification.
15. You have the right to know of fees to be charged and the methods and schedules of payment. (Including the turning over of any monies from public assistance grants, food stamps, social security disability income, etc.)

CONSENTS

16. You have the right to have any information regarding your identification and participation in the program treated confidentially in accordance with all local, state and federal laws.

17. You have the right to discharge yourself at any time.

18. You have the right to have your religious beliefs respected.

19. You have the right to be free from corporal punishment, physical abuse, sexual abuse, psychological and emotional abuse, financial exploitation, retaliation, harassment, humiliation, intimidation, threats, and involuntary physical confinement.

For detailed information related to your rights as a client, please see Florida Statute 397.501 (https://www.flsenate.gov/Laws/Statutes/2018/0397.501).

Client's Signature **Date**

Client's Printed Name

Client Name: _____ DOB: _____ Client ID#: _____

GUIDANCE/CARE CENTER, INC.

3000 41st Street, Ocean
Marathon, FL 33050
Phone: (305) 434-7660
Fax: (305) 434-9040

99198 Overseas Hwy., Ste. 5
Key Largo, FL 33037
Phone: (305) 434-7660
Fax: (305) 451-8019

1205 Fourth Street
Key West, FL 33040
Phone: (305) 434-7660
Fax: (305) 292-6723

CONSENT FORM: ASSESSMENT

PURPOSE OF THE ASSESMENT

Guidance/Care Center, Inc. provides supported substance abuse and mental health treatment services for residents of Monroe County. A comprehensive substance abuse and mental health assessment is used to assist the agency in determining each person's treatment needs. The purpose of the assessment is to access State of Florida, Department of Children and Families supported substance abuse and mental health treatment services. If the assessment indicates that you need residential treatment of substance abuse, the assessment and your information is submitted to the South Florida Behavioral Health Network. They will refer you to a treatment program when a place becomes available. The waiting period may vary, and you will be responsible for contacting the South Florida Behavioral Health Network to check on the status of your placement.

PROCEDURE:

The assessment involves an interview with a therapist from the Guidance/Care Center, Inc. You will be interviewed and asked questions concerning different aspects of your personal history. Some of the areas covered in the assessment will include your pattern of drug and alcohol use, mental health, legal history, health status, education, employment, finances, and living situation. You will also be asked questions about your friends and family, and the nature of your relationships with them. The assessment usually takes about 1½ hours. Certain criminal justice programs, Family Intensive Treatment Program and our Motivational Support programs include random urinalysis as part of the assessment process. Following the interview, if appropriate, you will be provided information about how to contact the South Florida Behavioral Health Network.

RISKS

You will also be asked to share personal information, which may cause some discomfort or emotional stress from discussing personal matters. If you are being abused or neglected, if you are abusing someone, or if you are a danger to yourself or others, by law we are required to report this to the proper authorities.

CONFIDENTIALITY

Another potential risk is a possible breach of confidentiality. Anything you tell us is personal and confidential to the extent permitted by law. Your information will be submitted to the South Florida Behavioral Health Network and will be reviewed by staff members of that agency. Authorized Guidance/Care Center, Inc. personnel or other agencies that are bound by the same provisions of confidentiality may review your records for audit purposes.

Information that you or another family member tells the therapist will not be shared with other members of the family without permission. If you tell us something that must be reported by law, you will be encouraged to tell your family or you will be present when the information is discussed with them.

Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by the Guidance/Care Center, Inc. Generally, the Guidance/Care Center, Inc. may not say to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser
UNLESS:

1. You consent in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by you either at the Guidance/Care Center, Inc. or against any person who works for the Guidance/Care Center, Inc. or about any threat to commit such a crime.

Client Name: _____ DOB: _____ Client ID#: _____

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate State or local authorities.

BENEFITS

There is no guarantee that these treatments will benefit you, and no benefits may be promised to you as a participant in the program. Completion of the assessment does not guarantee admission to one of the Guidance/Care Center, Inc. Programs. The decision for admission is based on the results of the assessment, your current needs, the level of care you currently require, and the ability of the Guidance/Care Center, Inc. to appropriately and adequately meet your needs. However, should you choose to enter treatment at the Guidance/Care Center, Inc., you may experience benefits such as reducing or stopping drug and/or alcohol use, improving your mental health, or experiencing other improvements in your life.

REIMBURSEMENT

There is no reimbursement for completing the intake assessment, entering treatment, or completing the program.

COSTS

The cost of assessment is determined by income and means. Full payment, insurance coverage, or a sliding fee scale may be applied towards the cost of your treatment.

RIGHT TO WITHDRAW

Participation in the assessment is voluntary, and you may choose to withdraw at any time. There will be no penalties should you choose to withdraw. If you refuse to be assessed at the Guidance/Care Center, Inc., every effort will be made to refer you for an alternative assessment. If you have been court ordered to be assessed, you also have the right to refuse the assessment. However, this may result in consequences from the court, such as an order to another assessment or incarceration.

You are encouraged to ask about anything you do not understand, and to consider your participation in the assessment and the consent form carefully before you agree to this assessment. You should understand that you may take as much time as necessary to think it over.

PERSONS TO CONTACT

You have the right to ask questions about this form or the assessment at any time. The therapist may also answer your questions at this time. If you have questions after the interview is completed or if you have questions about your rights as a participant, you may contact Maureen Kempa, Director of Adult, Children & Family Services at (305) 434-7660. You will receive a copy of the signed consent form.

I agree ____ I do not agree ____ to participate in the above outlined program

I agree ____ that my child _____ may participate in the above outlined program

AND

☐ I have read this consent form.
or
☐ This consent form has been read to me by _____.
and/or
☐ This consent form has been explained to me by _____.

_____	_____	_____
Signature of Client and/or Parent	Date	Print Name of Client
_____	_____	_____
Signature of Witness	Date	Print Name of Witness

Client Name: _____ DOB: _____ Client ID# _____

GUIDANCE/CARE CENTER, INC.

3000 41st Street, Ocean
Marathon, FL 33050
Phone: (305) 434-7660
Fax: (305) 434-9040

99198 Overseas Hwy., Ste. 5
Key Largo, FL 33037
Phone: (305) 434-7660
Fax: (305) 451-8019

1205 Fourth Street
Key West, FL 33040
Phone: (305) 434-7660
Fax: (305) 292-6723

CONSENT FORM: OUTPATIENT SERVICES

PURPOSE OF THE PROGRAM

You are being admitted into an outpatient substance abuse or mental health treatment program. The program is designed to provide outpatient services including treatment and rehabilitation services for adult men and women. The program provides a supportive, therapeutic environment to assist you with eliminating alcohol and substance use, improving social and emotional functioning, enhancing mental health functioning, improving work performance, and reducing risk factors and risk behaviors.

ADULT OUTPATIENT PROGRAM

The Adult Outpatient Program (OP) provides treatment to adults with substance abuse and/or mental health problems. The program uses a variety of therapy approaches, including, individual, group, couples, and family counseling and focuses directly on the role of alcohol and drugs, or mental health problems, as they relate to problem feelings and behaviors, and how problems may be solved without turning to alcohol and drugs. The treatment team may include clinically trained therapists, case managers, intervention coordinators and peer support specialists. The Adult OP includes, but is not limited to: individualized treatment plans, wellness and recovery action plans, drug education, random alcohol and drug tests as required, relapse prevention, support groups, and communication with community professionals (as appropriate). 12-Step participation is strongly recommended and may be required. Additional referrals for needed medical, psychiatric, or other services are available.

PROCEDURE

The first step in admission to the program is the intake evaluation. You will be interviewed and asked questions concerning different aspects of your personal history. Some of the areas covered in the assessment will include your pattern of drug and alcohol use, mental health, legal history, health status, education, employment, finances, and living situation. You will also be asked questions about your friends and family, and the nature of your relationships with them. The admission interview usually takes about 1½ hours. If you have health insurance coverage, the therapist may be required to contact your insurance plan for authorization of your treatment. Following the interview, you will be provided information about the location of the Outpatient Program and your start date.

RISKS

Participation in an Outpatient Program means that there will be some loss of privacy when you participate in group therapy. You will also be asked to share personal information, which may cause some discomfort or emotional stress from discussing personal matters. Noncompliance with program policies may also result in risk of discharge from the program for serious violations of program rules.

If you are being abused or neglected, if you are abusing someone, or if you are a danger to yourself or others, by law we are required to report this to the proper authorities.

Client Name: _____ DOB:_____Client ID#_____

CONFIDENTIALITY

Another potential risk is a possible breach of confidentiality. Anything you tell us is personal and confidential to the extent permitted by law. Information about your treatment will be discussed with the other staff members and therapists that are members of the treatment team or are involved with your treatment at the Guidance/Care Center, Inc. Authorized Guidance/Care Center, Inc. personnel or other agencies that are bound by the same provisions of confidentiality may review your records for audit purposes.

Information that you or another family member tells the therapist will not be shared with other members of the family without permission. If you tell us something that must be reported by law, you will be encouraged to tell your family or you will be present when the information is discussed with them.

Specific informed consent may be requested for clients that are court ordered to treatment. Your results from random urinalysis and your progress in treatment, but no specific information collected during assessments and therapy sessions, will be reported to the Probation Officer and/or Judge in instances where participation in the program is pertinent to ongoing court proceedings.

Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by the Guidance/Care Center, Inc. Generally, the Guidance/Care Center, Inc. may not say to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser UNLESS:

1. You consent in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by you either at the Guidance/Care Center, Inc. or against any person who works for the Guidance/Care Center, Inc. or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate State or local authorities.

BENEFITS

There is no guarantee that these treatments will benefit you, and no benefits may be promised to you as a participant in the program. However, you may experience benefits such as reducing or stopping drug and/or alcohol use, improving your mental health, or experiencing other improvements in your life.

REIMBURSEMENT

There is no reimbursement for completing the intake assessment, entering treatment, or completing the program.

COSTS

The cost of treatment is determined by income and means. Full payment, insurance coverage, or a sliding fee scale may be applied towards the cost of your treatment.

Client Name: _____ DOB: _____ Client ID# _____

RIGHT TO WITHDRAW

Participation in the program is voluntary, and you may choose to withdraw at any time. There will be no penalties should you choose to withdraw. If you refuse treatment from the Guidance/Care Center, Inc., every effort will be made to refer you to alternative treatments. If you have been court ordered into treatment, you also have the right to refuse such treatment. However, this may result in consequences from the court, such as an order to another treatment or incarceration.

You are encouraged to ask about anything you do not understand, and to consider your participation in the program and the consent form carefully before you agree to admission. You should understand that you may take as much time as necessary to think it over.

PERSONS TO CONTACT

You have the right to ask questions about this form or the program at any time. The intake therapist may also answer your questions at this time. If you have questions after the interview is completed or if you have questions about your rights as a participant, you may contact Maureen Kempa, Director of Adult, Child and Family Services at (305) 434-7660. You will receive a copy of the signed consent form.

I agree ____ I do not agree ____ to participate in the above outlined program and

☐ I have read this consent form.

or

☐ This consent form has been read to me by _____.

and/or

☐ This consent form has been explained to me by _____.

_____ _____

Signature of Client Date

_____

Print Client's Signature

_____ _____

Signature of Witness Date

_____

Print Witness's Name

Client Name: _____
Client DOB: _____
Client ID #: _____

HIPAA PRIVACY STANDARDS NOTICE
Effective Date: May 5, 2014

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d *et seq.*, 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2 2 and the Health Information Technology for Economic and Clinical Health ["HITECH"] Act of January 25, 2013.. Under these laws, WestCare Foundation, Inc. and all affiliates and subsidiaries ("WestCare") may not say to a person outside WestCare that you attend the program, nor may WestCare disclose any information identifying you as an alcohol or drug treatment patient, or disclose any other protected information except as permitted by federal law.

WestCare must obtain your written consent before it can disclose information about you for payment purposes. For example, WestCare must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. WestCare is also required to obtain your written consent before it can sell information about you or disclose information about you for marketing purposes, and WestCare must obtain your written consent before disclosing any of your psychotherapy records. Generally, you must also sign a written consent before WestCare can share information for treatment purposes or for health care operations. However, federal law permits WestCare to disclose information *without* your written permission:

1. Pursuant to an agreement with a qualified service organization/business associate;
2. For research, audit or evaluations;
3. To report a crime committed on WestCare's premises or against WestCare personnel;
4. To medical personnel in a medical emergency;
5. To appropriate authorities to report suspected child abuse or neglect;
6. As allowed by a court order.

> For example, WestCare can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

Before WestCare can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you orally or in writing.

Your Rights

Under HIPAA, you have the right to request restrictions on certain uses and disclosures of your health information.

a. If you request a restriction on disclosures to your health plan for payment or health care operations purposes, and you pay for the services you receive from WestCare yourself (out-of-pocket), then WestCare is required, by law, to agree to your request unless the disclosure is otherwise required by law.

b. If you have any other requests for restrictions on disclosures, WestCare is not required, by law, to agree. However, WestCare will thoroughly evaluate each request. If WestCare does agree, then WestCare is bound by that agreement and may not use or disclose any information which you have restricted, except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. WestCare will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by WestCare *[when WestCare uses electronic health records, the client/patient has a right to an electronic copy of his or her records]*, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in WestCare's records, and to request and receive an accounting of disclosures of your health related information made by WestCare during the six years prior to your request. You also have the right to receive a paper copy of this notice.

WestCare's duties

WestCare is required by law to maintain the privacy of your health information, provide you with notice of its legal duties and privacy practices with respect to your health information, and to notify you if you are affected by any breach of your unsecured health information. WestCare is required by law to abide by the terms of this notice. WestCare reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains.*[Should revisions be made, WestCare will provide all clients will the revised information and notice.]*

Complaints and Reporting Violations

You may complain to WestCare and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. You will not be retaliated against for filing such a complaint. Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Complaints and inquiries to WestCare shall be directed to WestCare's Privacy Officer at the following address:

Robert Neri, Senior Vice President, Privacy Officer
WestCare Foundation, Inc.
P. O. Box 12019, St. Petersburg, FL 33733-2019
Phone: (727) 490-6767 ext. 30105

Acknowledgement

I hereby acknowledge that I understand this notice and have received a copy.

Dated: _____ _____
(Signature of client/patient)

Printed Name: _____

5/6/14 mj;bn; mk060914

WESTCARE

Client Email/Texting Informed Consent Form

1. Risk of using email/texting

There are some risks if you send personal information by email and/or texting. You should think about these risks before you use email and/or texting. They include, but are not limited to, the following:

1. Emails and texts can be forwarded to others, stored electronically and on paper, and sent to people who you did not want to see it.
2. You easily can put the wrong address on an e-mail or text and send the information to the wrong person(s).
3. Backup copies of emails and texts may exist even after you and/or the recipient deletes his or her copy.
4. Employers and on-line services have a right to inspect emails sent through their company systems.
5. Emails and texts can be stopped, changed, forwarded or used without your permission or without you knowing about it.
6. Email and texts can be used as evidence in court.
7. Emails and texts may not be secure. Therefore, the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts

Your therapist, counselor, or case manager will do their best to keep emails and texts that they send and receive confidential. They are not responsible for someone else sending the emails or texts to others. They also are not responsible for someone else telling others what is in the e-mails or texts or for someone else using the e-mails in a wrong way.

You must agree and consent to the following:

1. Do not use email or texting for emergencies or for things that need fast answers. WestCare cannot promise that someone will read your email or text and answer it quickly.
2. Email and texts should be short and to the point. Do not include information that you do not want others to know or see. If there is something personal, sensitive, or confidential you need to talk about, you should call about it or make an appointment.
3. WestCare may print and file emails and/or texts in your medical record.
4. WestCare will not send your emails or texts to someone else without your written consent, except as authorized by law.
5. You should not use email or texts to send sensitive medical information.
6. WestCare is not liable for breaches of confidentiality caused by you or any third party.
7. It is your responsibility to follow up or schedule an appointment if needed.

WESTCARE

Client Email/Texting Informed Consent Form

3. Client Acknowledgement and Agreement

I read and understand this consent form. I know the risks of using email and/or texts to communicate with my therapist, counselor, or case manager. I agree to the information in this form. I agree to any other instructions that my therapist, counselor, or case manager gives me about emails or texts.

Client name: _____

Client signature: _____ Date: _____

Parent/Legal Guardian name: _____

Parent/Legal Guardian signature: _____ Date: _____

Provider name: _____

Provider signature: _____ Date: _____

Client ID #: _____

WESTCARE

Behavioral Health Treatment, HIV/AIDS, STD, and/or TB Care

Special Consent for the Release of Confidential Information
[Exchange of Information]

I, _____, authorize:

Guidance/Care Center, Inc. _____
Name of WestCare Specific subsidiary Address, Phone, Fax

and the following persons/entities involved in my treatment, services, and health to exchange information:

- **Health Care Provider(s) or other entity:**

_____ _____
[initial] **Name, address, phone number, and fax number**

- **Department of Health:**

_____Designated staff of the state/local Dept. of health responsible for TB, STD
[initial] and/or HIVAIDS prevention, control and care

_____
Name, Address, Phone number, and Fax number

PURPOSE: To communicate with and disclose to one another the information to be used to provide, coordinate and monitor care, treatment, and services and to discuss with me any [sexual/needle sharing, partners or contacts and/or family members who might be infected with HIV, STD and/or TB and need treatment.
[the nature and amount of information to be as limited as possible]

[*initial* **only** the category(ies) that applies]

_____ A. Behavioral Health treatment: Information about my participation and attendance in the treatment program(s) named above that is needed to enable the persons and agencies listed above to provide, coordinate, and monitor my treatment for HIV/AIDS, TB and/or STD.

_____ B. Tuberculosis (TB): Information about my diagnosis and treatment for TB that is needed to enable the persons and agencies listed above to provide, coordinate, and monitor my treatment for TB.

_____ C. Sexually transmitted disease(s) (STD): Information about my diagnosis and treatment for any STD that is needed to enable the persons and agencies listed above to provide, coordinate, and monitor my treatment for STD.

_____ D. HIV/AIDS: Information about my HIV status (including HIV test results and information about my diagnosis and treatment for HIV-related conditions, including AIDS) that is needed to enable the persons and agencies listed above to provide, coordinate, and monitor my treatment for HIV/AIDS.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the
Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that HIV-related information about me, STD-related information about me, and TB-related information about me is protected by state law and cannot be disclosed except as authorized by state law.

Client Name:_____ DOB:_____ Client ID:_____

I further understand that I may revoke this consent at any time, in writing, except to the extent that action has been taken in reliance on it, and **that in any event this consent expires automatically as follows:**

Date _____
[one year or less]

or Specific Event or Condition: _____
[example-date on when my treatment for TB or STD is completed]

Your records, which are the property of WestCare, are privileged and confidential. Your records will not be released without this Consent except under circumstances that fall into these categories: a valid medical emergency, receipt of a Court Order, receipt of a request which is governed by state statutes, internal communications, no-patient identifying information, research, audit and evaluation, crime at program/against program personnel, and child abuse.

I understand that generally WestCare may not condition my treatment on whether I sign a consent form, but that in certain limited circumstance I may be denied treatment if I do not sign this consent form.

Re-disclosure of Information: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

I have given my consent freely, voluntarily, and without coercion. I have been offered a copy of this form.

Client Signature: _____Date:_____

Printed Name:_____

Signature of person signing form if not client_____
Describe authority to sign on behalf of client: _____Date:_____

Printed Name:_____

Witness Signature: _____Date:_____

Printed Name:_____

State of Florida Department of Children and Families
Informed Consent or Post-Treatment Follow up Survey

The State of Florida wishes to learn if state funded substance abuse services are effective in reducing substance abuse and use. To do so, they contact some of the clients who received treatment 6 and 12 months after their treatment ends. If you agree to be surveyed, contact information you provide is entered into the Substance Abuse/Mental Health data system. Guidance/Care Center, Inc. staff contacts clients by telephone to conduct a brief follow-up survey. GCC provides a summary report of findings without individual indentifying information to the Department of Children and Families. All client information is protected by the Department and University of Florida to ensure confidentiality.

If you agree to be contacted, the Guidance/Care Center, Inc. will use your information to attempt to contact you within three (3) months following your discharge from treatment, in order to update your contact information. The information you provide will be used by Department of Children and Families only for the purpose of being able to contact you or someone else you designate and completing the follow-up survey.

You have the right to revoke your authorization in writing, without penalty, except to the extent it has already been relied upon or as use or disclosure in otherwise permitted by law. Upon notice of revocation, further use or disclosure of your contact information will cease immediately. If not revoked, your authorization will expire 18 months from the date you sign your consent.

Consent to be contacted and surveyed:
I, _____ (print client name),with date of birth_____
CHECK ONE:

☐ **DO** give permission to be contacted for purposes of obtaining follow-up information concerning my post-treatment behavior **AND My address and phone number is:**	☐ **DO NOT** give permission to be contacted for purposes of obtaining follow-up information concerning my post-treatment behavior. **STOP HERE IF YOU CHECKED THIS BOX AND SIGN NEXT PAGE**

_____

Street City State Zip Phone # 2nd Phone #

If the program is unable to reach me at this phone number, I give permission to speak with the following people listed below to inquire about any forwarding phone numbers or address where I may be reached. If follow-up personnel cannot reach me, I give permission for the person (s) named below to answer questions about my progress since leaving treatment by answering the questions in the follow-up survey to the best of their knowledge.

CONSENTS

Client Name: _____ DOB: _____ Client ID# _____

	Contact # 1 (*note: for adolescents, Guardian Name and Phone must go here)*	**Contact # 2**	**Contact # 3**
Print Name			
Relationship			
Primary Phone #			
Secondary Phone #			

_____ _____
Client Signature Date

_____
Print Client Name

_____ _____
Parent or Guardian Signature Relationship Date

_____
Print Parent's or Guardian's Name

_____ _____
Witness Signature Date

_____
Print Witness Name

PROGRAM (CHECK ONE):

_____OUTPATIENT MH-CHILD
_____OUTPATIENT MH-ADULT
_____OUTPATIENT SA-CHILD
_____OUTPATIENT SA-ADULT

_____INPATIENT DETOX
_____INPATIENT CSU
_____PERSONAL GROWTH CENTER
_____CASE MANAGEMENT-ADULT
_____CASE MANAGEMENT- CHILD
_____PREVENTION/DIVERSION

****

FOR OFFICE USE ONLY:

Discharge Date	Date of 1st Attempt/Results	Date of 2nd Attempt/Results	Date of 3rd Attempt/Results	Person Conducting Survey	Notes

GUIDANCE/CARE CENTER

CONSENT FOR THE DISCLOSURE

OF CONFIDENTIAL INFORMATION

(Reporting of Communicable Disease)

I, _____, born on _____,

authorize the Guidance/Care Center, to disclose to Monroe County Health Department, the following information:

1. Report of Diagnosis or suspicion of communicable disease for the purpose of reporting, and assisting in the medical evaluations and treatment of communicable disease.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: 1 year from the date of discharge from the program.

_____ Dated:_____/_____/_____

Client Signature

_____

Print Client's Name

_____ Dated:_____/_____/_____

Parent or Guardian

_____

Print Parent or Guardian

_____ Dated:_____/_____/_____

DCF Caseworker, if necessary

_____

Print DCF Caseworker, if Necessary

Informed Consent for Telehealth Services

Client Name: _____ **DOB:** _____
Last Name First Name

Location of client (program/site of service)**:** _____

Care Team Members (staff that maybe involved and/or present during telehealth sessions)**:**

Staff Name	**Position/Title**
Staff Name	**Position/Title**
Staff Name	**Position/Title**
Staff Name	**Position/Title**
Staff Name	**Position/Title**
Staff Name	**Position/Title**

Definition of Telehealth:

Telehealth includes telemedicine and various other services to improve a patient's health encompassing four distinct domains of application:

- Live Video, also known as synchronous, permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.
- Store-and-forward, also known as asynchronous, which is the transmission of recorded health history through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction.
- Remote patient monitoring (RPM), Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in care and related support.
- Mobile health (mHealth), Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and Personal Digital Assistant (PDAs).

Potential Benefits:

1. Improved access to care by enabling a patient to remain in his/her primary site care office (or at a remote site) while a Care Team Member can obtains test results and consults with healthcare practitioners at distant/other sites.
2. Obtaining the expertise of a distant Care Team Member who providers a service that might not otherwise be readily available.

Potential Risks:

As with any procedure/process, there are potential risks associated with the use of telehealth services. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate decision making by the Care Team Member(s).
2. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
3. Security protocols could fail, causing a possible breach of privacy of personal private information.
4. A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.

WESTCARE

Informed Consent for Telehealth Services

By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of private health information also apply to telehealth services.
2. No information obtained during a telehealth encounter which identifies me will be disclosed to researchers or other entities without my consent.
3. I have the right to withhold or withdraw my consent to the use of telehealth during the course of my care at any time. I understand that my withdrawal of consent will not subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled. However the withdrawal from telehealth care could limit my ability to receive services.
4. I have the right to inspect all information obtained and recorded during the course of a telehealth interaction.
5. A variety of alternative methods of care may be available to me, and I may choose one or more of these at any time. A Care Team Member has explained the alternative care methods to my satisfaction.
6. Telehealth may involve electronic communication of my private health information to other practitioners who may be located in other areas, including out-of-state, with a consent to release information.
7. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse.

Patient Consent To The Use of Telehealth.

I have read and understand the information provided above regarding telehealth, have discussed it with a Care Team Member such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

I hereby consent to and authorize _____ WestCare to use telehealth in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for Patient) Date

If authorized signer, relationship to Patient: Date

Witness Date

I have been offered a copy of this consent form (patient's initials) _____

9/8/2017 jh