LEDC
LIFE ENRICHMENT DAY CENTER
CARING & COMPASSIONATE FAMILY BUSINESS

LEDC INTAKE PACKET

After completing the form, please send it via email, fax, or in person to Mercifulmanagement@gmail.com. The fax number is 336-270-5156.

First Name:	**Middle:**	**Last Name:**
Street Address:	**County of Residence:**	
City:	**State:**	**Zip Code:**
Date of Birth:	**Social Security:**	**Gender:**
Race: **Ethnicity:**	**Marital Status:**	**Current Level of Education:**

CONTACT INFORMATION

Phone Number:	**Cell Phone:**	**Email:**
Case Manager: (if applicable)	**Agency:**	**Phone Number:**

PRIMARY INSURANCE

Medicaid: Y N	Medicaid #:	Medicare #:

EMERGENCY CONTACT

(Please provide information in case of an emergency)

Name: _____

Relationship: _____

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

LEGALLY RESPONSIBLE PERSON

(Please check one)

Self: ☐ Parent: ☐ Legal Guardian: ☐ Other: _____

Name: _____

Relationship: _____

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

CARE TEAM INFORMATION

PRIMARY CARE PROVIDER

Name: _____

Address: _____

City/State: _____ Zip Code: _____

Phone Number: _____

PSYCHIATRIST

Name: _____

Address: _____

City/State: _____ Zip Code: _____

Phone Number: _____

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THERAPIST	**OTHER AGENCY**
Name: _____	Name: _____
Address: _____	Name of Agency: _____
City/State: _____ Zip Code: _____	Office Phone: _____
Phone Number: _____	Cell Number: _____

LIVING ARRANGEMENT (check one)	**REFERRAL SOURCE (check one)**	**PREFERRED LANGUAGE (check one)**
o Private Residence o Other independent housing o Homeless shelter o Correctional facility o Residential Facility o Nursing home o Other: _____	o Self/no referral o Family/friends o State facility o Psychiatric service o Non-residential treatment/habilitation program o Community Agency o Court/corrections/prisons o Other: _____	o English o Sign Language o French o Spanish o Other

CONSENT OF PARTICIPATION IN PSYCHIATRIC REHABILITATION SERVICES

I, the undersigned, agree to participate in the Psychiatric Rehabilitation Program. I hereby give consent for the services to be provided.

I have been informed of the services that will be rendered including but not limited to:

- Self-Care Skills
- Independent Living Skills
- Employment Training
- Money Management
- Mental Wellness

_____/_____

Client (or Personal Representative) Date

I hereby affirm that all information provided on this form is correct and accurate to the best of my knowledge. It is my responsibility to inform Life Enrichment Day Center Inc. in writing of any changes to this information.

_____/_____

Client (or Personal Representative) Date

LEDC
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CARING & COMPASSIONATE FAMILY BUSINESS

CLIENT/PATIENT RIGHTS

1) You have the right to be fully informed of all your rights and responsibilities as a client/patient of the program.

2) You have the right to appropriate and professional care relating to your needs.

3) You have the right to be fully informed in advance about the care to be provided by the program.

4) You have the right to be fully informed in advance of any changes in the care that you may be receiving and to give informed consent to the provision of the amended care.

5) You have the right to participate in determining the care that you will receive and in altering the nature of the care as your needs change.

6) You have the right to voice your grievances with respect to the care that is provided and to expect that there will be no reprisal for the grievance expressed.

7) You have the right to expect that the information you share with the agency will be respected and held in strict confidence, to be shared only with your written consent and as it relates to the obtaining of other needed community services.

8) You have the right to expect the preservation of your privacy and respect for your property.

9) You have the right to receive a timely response to your request for service.

10) You shall be admitted for service only if the agency has the ability to provide safe and professional care at the level of intensity needed.

11) You have the right to be informed of agency policies, changes, and costs for services.

12) If you are denied service solely on your inability to pay, you have the right to be referred elsewhere.

13) You have the right to honest, accurate information regarding the industry, agency, and of the program.

14) You have the right to be fully informed about other services provided by this agency.

_____

Name of Person Receiving Services or Legally Responsible Person **Date**

_____

Signature of Person Receiving Services or Legally Responsible Person **Date**

PRIDE IN NORTH CAROLINA GRIEVANCE PROCEDURES

1) If you have a concern, please bring it to the immediate supervisor or QP.
2) If the concern is not resolved after discussing it with the supervisor or QP, then we ask that you complete a Grievance / Appeal Report and submit it to the Regional Director or Program Coordinator. The Regional Director or Program Coordinator will meet with you and the supervisor within three working days.
3) The Regional Director or Program Coordinator will document his/her decision on the Grievance form and review it with you.
4) You will be asked to sign off on the form and indicate if you agree with the decision, or if you would like to appeal it. You will also have space to make additional comments regarding the decision.
5) If you elect to appeal, the Regional Director / Program Coordinator will forward the report to the Chief Executive Officer (CEO) within 24 hours.
6) The CEO will make a decision concerning the Grievance / Appeal Report within five working days of receipt. The CEO's decision concerning the appeal will be forwarded back to the Regional Director or Program Coordinator.
7) The Regional Director or Program Coordinator will notify both you and the supervisor of the CEO's decision.
8) The CEO may seek additional information from any source when rendering a decision. All decisions by the CEO are final.
9) Anyone who completes a Grievance or Appeal will be free from interference, coercion, discrimination, penalty, reprisal, or any action of retaliation or barriers to services.
10) If you would like an external review, PRIDE In North Carolina staff will assist you in contacting any Advocacy Agency, Department of Social Services, or any other advocate that you choose.
11) All Grievance / Appeal Reports will be forwarded to the Human Rights Committee.

_____

Name of Person Receiving Services or Legally Responsible Person **Date**

_____

Signature of Person Receiving Services or Legally Responsible Person **Date**

NOTICE OF PRIVACY PRACTICES OF

Life Enrichment Day Center Inc.

Life Enrichment Day Center Inc. must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of *Life Enrichment Day Center Inc.* to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care and for other services relating to your health care.

The purpose of this *Notice of Privacy Practices* is to inform you about how your health information may be used within Life Enrichment Day Center Inc., as well as reasons why your health information could be sent to other service providers outside of this agency.

This *Notice* describes your rights regarding the protection of your health information and how you may exercise those rights. This *Notice* also gives you the names of contacts should you have questions or comments about the policies and procedures Life Enrichment Day Center Inc. uses to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Client Acknowledgement

I have received Life Enrichment Day Center Inc.'s *Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.

_____

Name of Person Receiving Services or Legally Responsible Person **Date**

_____

Signature of Person Receiving Services or Legally Responsible Person **Date**

Date

Note: LEDC retains this signed page. Client retains the Notice of Privacy Practices document.

NOTICE OF PRIVACY PRACTICES
Life Enrichment Day Center Inc.

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Responsibilities of Life Enrichment Day Center Inc.

Life Enrichment Day Center Inc. is required by state and federal law to protect the privacy of your health information that may identify you. This health information includes mental health, developmental disability and/or substance abuse services that are provided to you, payment for those health care services, or other health care operations provided on your behalf.

This agency is required by law to inform you of our legal duties and privacy practices with respect to your health information through this *Notice of Privacy Practices*. This *Notice* describes the ways we may share your past, present, and future health information, ensuring that we use and/or disclose this information only as we have described in this *Notice.* We do, however, reserve the right to change our privacy practices and the terms of this *Notice*, and to make the new *Notice* provisions effective for all health information we maintain. Any changes to this *Notice* will be posted [in our agency offices *(applies only to providers with direct relationship)*] and on our agency website at www.ledaycenter.com. Copies of any revised *Notices* will be available to you upon request.

If at any time, you have questions or concerns about the information in this *Notice* or about our agency's privacy policies, procedures, and practices, you may contact our agency Privacy Official at 336-270-5155.

Use and Disclosure of Health Information without Your Authorization

Treatment

Life Enrichment Day Center Inc. may use your health information, as needed, to provide, coordinate or manage your health care and related services. This includes sharing your health information with other healthcare providers within this agency.

> **Example:** Your treatment/habilitation team, composed of staff such as doctors, nurses, and social workers, will need to review your treatment and discuss plans for your discharge.

We will disclose your health information outside of this agency for treatment purposes only with your consent or when otherwise allowed under state or federal law. [*The following is based upon State law (GS 90-109.1) and applies to substance abuse providers, "If you request treatment and rehabilitation for drug dependence, your request will be treated as confidential. We will not refer you to another person for treatment and rehabilitation without your consent."]*

> **Example:** We may disclose your health information to other mental health facilities or professionals (i.e., community-based area mental health, developmental disabilities, and substance abuse services program or psychiatric service at UNC Hospitals) in **order** to coordinate your care.

Example: We may share your health information with a healthcare provider for emergency services.

Payment for Services

The treatment provided to you will be shared with our agency's billing department so a bill can be prepared for services rendered. We may also share your health information with agency staff who review services provided to you to make certain you have received appropriate care and treatment. We will not disclose your health information outside of this agency for billing purposes (i.e., bill your insurance company) without your consent *[the following exception is not applicable to substance abuse providers]* except in certain situations when we need to determine if you are eligible for benefits such as Medicaid, Medicare or Social Security.

Example: A Social Worker may contact your local Department of Social Services to determine if you are currently eligible for Medicaid or if you would qualify for Medicaid. *(Example not applicable for substance abuse providers)*

Example: Our billing department will collect insurance and other financial information from you at the time of admission.

Health Care Operations

Life Enrichment Day Center Inc. may use or disclose your health information in performing a variety of business activities that we call "health care operations". Some examples of how we may use or disclose your health information for healthcare operations are:

- Review the care you receive here and evaluate the performance of your treatment/habilitation team to ensure you have received quality care.
- Review and evaluate the skills, qualifications, and performance of health care providers who are taking care of you.
  - Provide training programs for agency staff, students, and volunteers.
  - Cooperate with outside organizations that review and determine the quality of care that you receive.
  - Provide information to professional organizations that evaluate, certify, or license health care providers, staff, or facilities.
  - Allow our agency attorney to use your health information when representing this agency in legal matters.
  - Resolve grievances within our agency.
  - Provide information to your internal client advocate who is available to represent your interests upon your request.

Other Circumstances

Life Enrichment Day Center Inc. may disclose your health information for those circumstances that have been determined to be so important that your authorization may not be required. Prior to disclosing your health information, we will evaluate each request to ensure that only necessary information will be disclosed. Those circumstances include disclosures that are:

- Required by law.
- For public health activities. For example, we may disclose health information to public health authorities if you have a communicable disease and we have reason to believe, based upon information provided to us, that there is a public health risk such as evidence of your noncompliance with your treatment plan. If you suffer from a communicable disease such as tuberculosis or HIV/AIDS, information about your disease will be treated as confidential. Other than circumstances described to you in other sections of this Notice, we will not release any information about your communicable disease except as required to protect public health or the spread of a disease, or at the request of the State or Local Health Director.

- Regarding abuse, neglect, or domestic violence; *(Not applicable to substance abuse providers – for substance abuse providers say "Regarding child abuse or neglect")*
- For health oversight activities such as licensing of nursing homes.
- For law enforcement purposes unless otherwise prohibited by state or federal law; [*Not applicable to substance abuse providers – for substance abuse providers say, "If you request treatment and rehabilitation for drug dependence, we will not disclose your name to any police officer or other law-enforcement officer unless you authorize such disclosure; except that if you later commit a crime or threaten to commit a crime on the premises of this agency or against program personnel, law enforcement may be notified."]*
- For court proceedings such as court orders to appear in court;
- Related to death such as disclosure to a funeral director;
- Related to donation of organs or tissue;
- To avert a serious threat to the health or safety of a person or the public;
- Related to specialized government activities such as national security;
- To correctional institutions or other law enforcement officials when you are in their custody;
- For Worker's Compensation in cases pending before the Industrial Commission; (*Not applicable to substance abuse providers)*
- To your next of kin or other person involved in your care upon their request; however, information to be disclosed will be limited to admission, transfer, discharge, referrals and appointments and you will be notified of this request; *(Not applicable to substance abuse providers)* and
- Related to medical research.

Disclosure of Your Health Information That Allows You An Opportunity To Object

There are certain circumstances where we may disclose your health information and you have an opportunity to object. Such circumstances include:

- The professional responsible for your care may disclose your admission to or discharge from this agency to your next of kin *(Not applicable to substance abuse providers)*
- Disclosure to public or private agencies providing disaster relief.

  Example: We may share your health information with the American Red Cross following a major disaster such as a flood.

If you would like to object to our disclosure of your health information in either of the situations listed above, please contact our agency Privacy Official listed in this *Notice* for consideration of your objection.

Disclosure of Your Health Information That Requires Your Authorization

Life Enrichment Day Center Inc. will not disclose your health information without your authorization except as allowed or required by state or federal law. For all other disclosures, we will ask you to sign a written authorization that allows us to share or request your health information. Before you sign an authorization, you will be fully informed of the exact information you are authorizing to be disclosed/requested and to/from whom the information will be disclosed/requested.

You may request that your authorization be canceled by informing our agency Privacy Official that you do not want any additional health information about you exchanged with a particular person/agency. You will be

asked to sign and date the Authorization Revocation section of your original authorization; however, verbal authorization is acceptable. Your authorization will then be considered invalid at that point in time; however, any actions that were taken on the authorization prior to the time you canceled your authorization are legal and binding.

If you are a minor who has consented to treatment for services regarding the prevention, diagnosis, and treatment of certain illnesses including venereal disease and other diseases that must be reported to the State; pregnancy; abuse of controlled substances or alcohol; or emotional disturbance, you have the right to authorize the disclosure of your health information. Disclosure of health information to external client advocates will require authorization by you and your personal representative if one has been designated. *(The following applies to substance abuse providers only – "If you are a minor whose parent or guardian has consented to your treatment for substance abuse, both you and your parent or guardian must authorize the disclosure of your health information.")*

Your Rights Regarding Your Health Information

You have the following rights regarding your health information as created and maintained by this agency.

Right to receive a copy of this *Notice*

You have the right to receive a copy of *Life Enrichment Day Center Inc.*'s *Notice of Privacy Practices*. At your first treatment encounter with this agency, you will be given a copy of this *Notice* and asked to sign an acknowledgment that you have received it. In the event of emergency services, you will be provided the *Notice* as soon as possible after emergency services have been provided.

In addition, copies of this *Notice* have been posted in several public areas throughout this agency and on the *Life Enrichment Day Center Inc.*'s Internet website at *www.ledaycenter.com*. You have the right to request a paper copy of this *Notice* at any time from our agency Admissions Officer or our agency Privacy Official.

Right to request different ways to communicate with you

You have the right to request to be contacted at a different location or by a different method. For example, you may request all written information from this agency be sent to your work address rather than your home address. We will agree with your request as long as it is reasonable to do so; however, your request must be made in writing and forwarded to our agency Privacy Official.

Right to request to see and copy your health information

Whether you are a minor, incompetent adult, or competent adult, you have the right to request to see and receive a copy of your health information in medical, billing, and other records that are used to make decisions about you. Your request must be in writing and forwarded to our agency Privacy Official. You can expect a response to your request within 30 days. If your request is approved, you may be charged a fee to cover the cost of the copy.

Instead of providing you with a full copy of your health information record, we may give you a summary or explanation of your health information, if you agree in advance to that format and to the cost of preparing such information.

Your request may be denied by your physician or a professional designated by our agency director under certain circumstances. If we do deny your request, we will explain our reason for doing so in writing and describe any rights you may have to request a review of our denial. In addition, you have the right to contact our agency Privacy Official to request that a copy of your health information be sent to a physician or psychologist of your choice.

Whenever you have a personal representative who consented to your treatment, the personal representative has the same rights to request to see and copy your health information.

Right to request amendment of your health information

You have the right to request changes in your health information in medical, billing, and other records used to make decisions about you. If you believe that we have information that is either inaccurate or incomplete, you may submit a request in writing to our agency Privacy Official and explain your reasons for the amendment. We must respond to your request within 30 days of receiving your request. If we accept your request to change your health information, we will add your amendment but will not destroy the original record. In addition, we will make reasonable efforts to inform others of the changes, including people you name who have received your health information and who need the changes.

We may deny your request if:

- The information was not created by this agency (unless you prove the creator of the information is no longer available to change the information);
- The information is not part of the records used to make decisions about you;
- We believe the information is correct and complete; or
- Your request for access to the information is denied.

If we deny your request to change your health information, we will explain to you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If you provide a written statement, the statement will become a permanent part of your record. Whenever disclosures are made of the information in question, your written statement will be disclosed as well.

Right to request a listing of disclosures we have made

You have a right to a written list of disclosures of your health information. The list will be maintained for at least six years for any disclosures made after April 14, 2003. This listing will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed and the purpose of the disclosure.

This agency is not required to include the following on the list of disclosures:

- Disclosure for your treatment;
- Disclosure for billing and collection of payment for your treatment;
- Disclosures related to our healthcare operations;
- Disclosures that you authorized;
- Disclosures to law enforcement when you are in their custody; or
- Disclosures made to individuals involved in your care.

Your first request for a listing of disclosures will be provided to you free of charge. However, if you request a listing of disclosures more than once in a 12-month period, you may be charged a reasonable fee. We will inform you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to request restrictions on uses and disclosures of your health information

You have the right to request that we limit our use and disclosure of your health information for treatment, payment, and healthcare operations. You also have the right to request a limit on the health information we disclose about you to your next of kin or someone who is involved in your care. (Example: you could ask that we not disclose information about your family history of heart disease.) We will provide you with a form to document your request.

We will make every attempt to honor your request but are not **required** to agree to such a request. However, if we do agree, we must follow the agreed-upon restriction (unless the information is necessary for emergency treatment or unless it is a disclosure to the U.S. Secretary of the Department of Health and Human Services).

You may cancel the restrictions at any time, and we will ask that your request be in writing. In addition, this agency may cancel a restriction at any time, as long as we notify you of the cancellation.

Violations/Complaints

(Applicable to substance abuse providers – "Violation of the Federal law and regulations relative to a substance abuse program is a crime. Suspected violations may be reported to our agency Privacy Official who will report the violation to appropriate authorities in accordance with Federal regulations.")
If you believe we have violated your privacy rights, or if you want to file a complaint regarding our privacy practices, you may contact our agency Privacy Official. Contact information is as follows:

Life Enrichment Day Center Inc. Privacy Official
1522 Vaughn Road
Burlington, NC 27217

Phone Number: 336-270-5155
Fax Number: 336-270-5156
Email address: Mercifulmanagement@gmail.com

The North Carolina Department of Health and Human Services operates an information and referral service located in the Office of Citizen Services, known as **CARE-LINE**, which has been designated to receive and document complaints and concerns regarding your privacy. Contact information is as follows:

CARE-LINE
2012 Mail Service Center
Raleigh, NC 27699-2012

Voice Phone (English and Spanish):
1-800-662-7030 (Toll Free)
(919) 733-4261 (Triangle Area and Out of State)

FAX: (919) 715-8174
TTY: 1-877-452-2514 (TTY Dedicated)
(919) 733-4851 (TTY Dedicated for local or out of state calls)
Email: care.line@ncmail.net

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. Contact information is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

Voice Phone: (404) 562-7886
FAX: (404) 562-7881
TDD: (404) 331-2867

If you file a complaint, we will not take any action against you or change the quality of health care services we provide to you in any way.

Legal References

Primary Federal and State laws and regulations that protect the privacy of your health information are listed below.

Confidentiality of Alcohol and Drug Abuse Patient Records – 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations.

Health Insurance Portability and Accountability Act (HIPAA), Administrative Simplification, Privacy of Individually Identifiable Health Information – 42 U.S.C. 1320d-1329d-8 and 42 U.S.C. 1320d-2(note) for Federal laws and 45 CFR Parts 160 and 164 for Federal regulations.

NC General Statutes – Chapter 122C, Article 3 (Client's Rights and Advance Instruction), Part 1 (Client's Rights). Chapter 90 (Medicine and Allied Occupations), Article 1 (Practice of Medicine).

NC Administrative Code – 10 NCAC 18 D (Confidentiality Rules).

LEDC
LIFE ENRICHMENT DAY CENTER
CARING & COMPASSIONATE FAMILY BUSINESS

Life Enrichment Day Center Inc.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, the Undersigned, authorize: **Life Enrichment Day Center** and authorized staff members to release and receive written and/or verbal information related to the client listed to the person or agency indicated below:

Client Name: _____ **Date of Birth**: _____

Once completed and signed, this authorization will remain in effect until: _____
(one year from the date signed)

The Mental Health Information Authorized for Release includes: (Check all that apply)

☐ Copies of Records ☐ Discharge Summaries ☐ Consultation

☐ School Visitation ☐ Immunization Records ☐ Scheduling

☐ Psychiatric Records ☐ Other Information: _____

Person/Organization authorized to receive your information:

☐ Case Worker ☐ Lawyer ☐ Parole/Probation Officer

☐ Psychiatrist ☐ Therapist ☐ Other: _____

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Purpose of Release: _____

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

I acknowledge that the information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. I specifically authorize the release of confidential information relating to drug and/or alcohol abuse, psychiatric, HIV results, and AIDS information. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR 2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____

Name of Person Receiving Services or Legally Responsible Person **Date**

_____

Signature of Person Receiving Services or Legally Responsible Person **Date**

LIFE ENRICHMENT DAY CENTER INC.

AUTHORIZATION FOR TREATMENT/HABILITATION

I, _____ individually or in my capacity as the legally responsible person for the person receiving services, voluntarily authorize and consent to treatment/habilitation, including, but not limited to, diagnostic, preventative, and therapeutic services. I understand this consent shall remain in effect until I notify the facility in writing that I no longer consent to treatment/habilitation. I understand that no guarantees have been made to me regarding treatment/habilitation. I understand that I should ask questions and/or discuss any concerns with my provider. I understand that I cannot smoke inside the facility.

AUTHORIZATION FOR EMERGENCY TREATMENT/HABILITATION

In case of an emergency, I authorize **Life Enrichment Day Center** to obtain emergency treatment/habilitation from any necessary physician, emergency room, and/or emergency transportation service.

AUTHORIZATION FOR TRANSPORTATION

I consent to **Life Enrichment Day Center** or other entities contracted with the facility to transport me related to the services I receive through the facility.

HEALTH INFORMATION RELEASE

I authorize the **Life Enrichment Day Center** to share health information on my behalf. This includes physicians, hospitals, laboratories, pharmacies, dentists, and other health care providers included on my treatment team. I authorize all listed parties to have access to important medical information about me that can assist in making medical decisions for me. Also, information about medications, allergies, and laboratory results was gathered during encounters with my healthcare provider. Records will also include my demographic data.

CONSENT FOR SUPPORT SERVICES FOR MEDICAID CONSUMERS

I agree to actively participate in all assessments and treatment/habilitation team processes related to my services. I agree to notify team members of my desire to change my service or service delivery methods.

CONSENT TO BE PHOTOGRAPHED

I hereby give permission for Life Enrichment Day Center to use photos and videos of me in publications, news releases, online, on appropriate websites, social media, and in other communications related to the mission of _____.

It is understood my signature/guardian or authorized representative on my behalf reflects an acknowledgment of the agreement with the above statements. I understand that all permissions may be withdrawn at any time through written notification to_____.

_____

Name of Person Receiving Services or Legally Responsible Person **Date**

_____

Signature of Person Receiving Services or Legally Responsible Person **Date**