Initial Assessment Summary Sheet

Client Name:

SmartCare ID:

Level of Care:

Group Days:

Assigned Counselor:

Start Date:

Individual Scheduled: YES NO

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Ritter Center Safety Net Outpatient Program

Client Income Declaration Form

Safety Net will use the information you give on this form only to see if you qualify for sliding scale Program if you become uninsured or are currently uninsured. The Sliding Scale may let you pay a reduced price for certain services or receive them for free. Patients insured by Medi-Cal will not be directly charged for services. No one will be denied entrance to this program due to inability to pay.

1. **Name (Please Print):** _____
2. **What is your monthly income, before taxes taken out?** _____
3. **What is your household's combined income?** _____
4. **Where does this money come from? (Work, disability, etc.)** _____
5. **How many family members live with you? (Count you're your spouse and children)**

_____

_____ _____ _____

Client Name (Printed) **Client Signature** **Date**

Health Screening

Have you or any of your immediate family members experienced/experiencing the following?

	Not Applicable	Myself	Family Member	Myself & Family
Allergies				
Lung Disease				
Brain Disorder				
Pancreatitis				
Diabetes				
STD				
Gynecological				
Tuberculosis				
High Blood Pressure				

Kidney Disease				
Arthritis				
Muscle Disorder				
Cirrhosis of Liver				
Seizure Disorder				
GI Disorder				
Thyroid Disorder				
Hepatitis				
High Cholesterol				
Anemia				
Migraines/Cluster Headaches				
Cancer (type)				
Psychiatric Disorder				
Stroke				
Heart Disease				
Ulcers				
Low Blood Pressure				
Mental Health				
Immune Disease				
Alcohol/Drug Dependence				

Do you have any other medical conditions/complications:

_____

Have you ever had a heart attack or any problem associated with the heart?

Yes _____ No _____

Are you currently experiencing chest pain(s)? Yes _____ No _____

Have you had a head injury in the last six (6) months? Have you ever had a head injury that resulted in a period of loss of consciousness? Yes ____ No ____

Do you have any open lesions/wounds? Yes _____ No _____

Do you use a C-PAP machine or dependent upon oxygen? Yes _____ No ____

Vision

Do you wear or need to wear glasses, contact lenses, or hearing aids? Yes ____ No ___

Details: _____

Dental

When was your last dental exam? Date:

Are you in need of dental care? Yes _ No ___

Details: _____

Do you wear or need to wear dentures or other dental appliances that may require dental care? Yes _____ No ___

Do you have a primary healthcare physician (PHP)? Yes ____ No _____

Date of last physical exam? _____

Are you currently under medical care for any physical health reasons? Yes ____ No _____

If yes, who is your provider and where are they located? _____

Are you pregnant? Yes ___ No ____ If yes, when are you due? _____

Are you receiving prenatal care? Yes ____ No _____ If yes, where? _____

Do you currently use any prescription medications, or over the counter meds, or alternative substances (herbs, vitamins, etc.)? If so, please list name and dose and how often taken.

_____

_____

_____

Have you had any changes in your medications in the past 30 days? Yes _____ No _____

If yes, please explain.

_____

List all hospital admissions and/or surgeries in the past 5 year:

_____

_____

_____

In the 30 days before you came to Safety Net, did you have unprotected sexual contact or share needles with someone who is HIV positive or

has AIDS or was an IV drug

user? Yes ____ No __

Would you be interested in talking with someone about the possibility of starting a medication to help address an opioid or alcohol use?

Yes __ No ___

Do you have any strong feelings about medications already? Yes ____ No ___

In other words, do have a specific medication in mind, or are you new to this and open to talking with someone about all the various medication options?

Yes __ No ___

Would you like us to help connect you with a provider that can prescribe medication assisted treatment? Yes ____ No ____

Are you familiar with Narcan? Would you like some resources/instructions on how to obtain Narcan? Yes _____ No ____

I declare that the above information is true and correct to the best of my knowledge:

Client Signature: _____ **Date:** _____

Reviewing Facility/Program Staff Name: _____

Reviewing Facility/Program Staff Signature: _____ **Date:** _____

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ADMISSION AGREEMENT

Ritter Center Safety Net Outpatient Program

Right to Confidentiality

The conditions of treatment and services have been fully explained to my satisfaction and understanding. I and aware that records concerning my treatment will be retained. These records and information will be kept confidential pursuant to 42 CFR, Part 2 regulations. What is discussed in treatment is confidential unless I consent to its release, or as otherwise authorized or mandated by law. Two examples of such exceptions by law include those circumstances in which: (1) Ritter Center Safety Net clinical staff hear or believe that an individual is in danger of hurting him/herself or someone else; and (2) there is a reasonable suspicion that a child has been neglected or abused.

Fees Assessed and Services Provided

I may be charged for services based on my ability to pay with the exception of Medi-Cal beneficiary with no share of cost. I understand that if I am a Medi-Cal beneficiary, then I can receive State Plan Drug/Medi-Cal benefits regardless of County of residence. As Drug/Medi-Cal services cannot be claimed for out of county beneficiaries due to Drug/Medi-Cal Organized Delivery System (DMC-ODS) requirement, Ritter Safety Net staff will assist me to receive benefits from my county of residence or another county that is not opting into the DMC-ODS. I agree to complete a Financial Responsibility form as part of the intake process or at first service contact, and annually thereafter or as frequently as changes in financial, insurance, or eligibility status may warrant. This will be used to determine my fees, if any. I understand that I cannot be denied services based solely on inability to pay.

Grievance Procedure/Right to File a Complaint

If I have a problem that I cannot resolve successfully with my counselor/therapist and his/her supervisor, I can call the Ritter Center at BHRS Alcohol & Drug Administrator at 415-473-6652. I can also contact the California Department of Health Services—Substance Use Disorder Services Compliant Compliance Division at 916-322-2911 or toll free at 1-877-685-8333. I also have the right to file a grievance verbally by calling the BHRS Access Line at 1-888-818-1115 (toll free) or in writing by completing a grievance form, which is available in the lobby area or at www.MarinHHS.org/DMCWaiver.

If you feel your privacy rights have been violated and wish to file a complaint, or have any other questions or concerns about our privacy practices, please contact our Privacy officer: privacy@rittercenter.org or call toll free 888-368-4111.

- Filing a complaint will not negatively affect the services you receive from Ritter Center.
- You may also file a complaint directly with the USDH Office of Civil Rights

200 Independence Avenue, S.W. Washington, D.C. 20201 Ph: 877-696-7775 OCRMail@hhs.gov www.hhs.gov

Program Rules and Guidelines

1. You should be prepared, in your seat, and ready to begin group or individual services on time.
2. IOP/OP clients are expected to attend ALL group and individual sessions. If you need to cancel a group or individual session, please do so 24 hours in advance of your appointment. During the Intensive Outpatient/Outpatient Program you are allowed to have 2 unexcused (No Call/No Show) and 2 excused absences (Notified in advance) from treatment. If you exceed this allowance you will be issued a verbal warning. If continued absences occur you will be placed on a developmental plan. If developmental plan is not followed you will be discharged from the program.

3. Participate with your counselor/therapist in developing your treatment and recovery plans and in assessing progress towards achieving treatment plan goals.

4. Clients must have 24 hours clean/sober from illicit substances or any misuse of prescribed substances. If you are under the influence you will not be able to participate in group services on that day and will be asked to return to the next session. Program staff will work with you to address relapse and may refer you to detoxification services, if deemed appropriate. Repeated occurrences may result in a referral to a higher level of care.

5. Please keep other group members identities and discussions confidential for the purpose of group safety, privacy, and effectiveness. You may not talk about what happens in group sessions other than your own experiences.

6. Random drug screens can be given at any time and are a normal part of the program. If you refuse to provide a screen it will be counted as a positive screen.

7. Report any changes in address, telephone number, employment and insurance to program staff.

8. You are asked to be respectful of others' sexual preferences/race and putdowns to either sexes or race will NOT be tolerated.

9. Please do not use your cell phone during sessions. Please turn off or keep them on silent during group and individual.

10. Verbal threats or aggression are grounds for discharge.

11. Weapons, illegal drugs, and other contraband are not permitted on any Safety Net premises

Telehealth Specific Rules

1. Each member must sign into group on their own device.

2. Please use the mute option when not speaking to avoid background noise.

3. If you plan to attend a group session please remain in group for the entire session. If you are going to be more than 15 minutes late inform your counselor.

4. Please find a quiet and comfortable place to participate.

5. Others **must not be present** to keep the confidentiality of others and yourself. You will be removed if confidentiality is compromised. (Headphones help!)

6. Please keep your camera on unless specifically discussed with counselor.

7. Do not drive or operate any motorized vehicle while participating in telehealth.

8. Participants will need to download material for group and come to every group prepared with a notebook and writing utensils to be ready for journaling or worksheets.

9. Participants will fully engage in group sessions by sharing personal experiences during check in and discussing topics presented by the facilitator.

10. During break please mute and turn camera off and return promptly after 15 minutes.

Activities Expected of Participants

1. I agree to participate in the completion of assessment forms to ensure quality of care in the delivery of substance use services and other inter-agency outcome measures.
2. I will be asked to participate in developing my treatment plan and goals with my case counselor/therapist. I can receive a copy of my treatment plan.
3. Though it is not required, I will be asked to consent to exchange pertinent information with mental health and other relevant service providers for the express purpose of coordinating care in order to provide an integrated treatment experience.
4. I agree to participate in the individual and group counseling, drug screening and other services identified in my treatment plan.

Reasons for Termination

Termination from the program can result from the following:

1. Meeting medical necessity for a higher or lower level of care, in which case, program staff would assist in a referral.

2. Violating program rules and regulations, including, but not limited to: not attending scheduled appointments and violating the attendance policy, engaging in acts of violence or aggression; possession of non-prescribed alcohol and/or drugs on the premises; carrying or displaying weapons on the premises; committing illegal acts on the premises.

Fair Hearing Rights

If I am a Medi-Cal beneficiary, in the instances of a denial or reduction in service or an involuntary discharge, I will be advised in writing (10) calendar days prior to the action to terminate or reduce services. The written notice will include:

1. A statement of the action the program intends to take;
2. The reason for the intended action;
3. A citation of the specific regulation(s) supporting the intended action;
4. And explanation of the clients right to a fair hearing for the purpose of appealing the intended action;
5. An explanation that the client may request a fair hearing by submitting a written request to: California Department of Social Services, State Hearings Division, PO Box 944243, Mail Station 9-17-37, Sacramento, CA 94244-2430. Tel: 1-800-952-5253/ TDD: 1-800-952-8349.
6. An explanation that the program will continue treatment services pending a fair hearing decision only if the client appeals in writing to the Department of Social Services for a hearing within 10 calendar days of the mailing or personal delivery of the notice of intended action.

All Fair Hearings shall be conducted in accordance with California Code of Regulations Title 22, Section 50953.
Acknowledgement: By signing this document, I acknowledge that I understand and agree to the following:

1. I have read this consent form and I understand its content and agree to its conditions. I understand that I can withdraw consent and terminate from this program and its services at any time by notifying the program by providing the services in writing. I further understand that participation in outpatient treatment is voluntary and is not a prerequisite for access to other services. I understand that I am expected to benefit from treatment, but there is no guarantee that I will. Maximum benefits will occur with regular

attendance, but I may feel temporarily worse while in treatment.

2. I have been given a 24/7 phone number in the event of an urgent/emergent need.

3. I have received a copy of the **Notice of Privacy Practices**, which informs clients how H&HS may use and/or disclose their protected health information.

4. I have read and understand my rights and how to file a Grievance, Appeal, or Expedited Appeal. I also have read and understand my rights to a **Fair Hearing** and have been given a copy of this agreement, which contains said information. I also understand that should any benefits be reduced, modified, delayed or terminated, the County of Marin will mail me a Notice of Adverse Benefit Determination, to the address on record.

5. I have read and understand the **Program Rules and Regulations** and have been given a copy of this agreement, which contains said information.

6. I have been offered a copy of **Marin County health and social services referrals.**

7. I have been offered the Drug/Medi-Cal Organized Delivery System Beneficiary Booklet and Provider Directory and have been advised of my right to request and obtain this information at least one year and thereafter upon request.

8. Copies of informational materials in alternative formats (e.g. CD, large font, non-English) can be provided by your counselor/therapist.

Expiration: This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: _____ **Date/Event (End of my services at Safety Net Outpatient Treatment Program, if left blank.)**

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

Authorization to Bill My Health Insurance:

I understand that Safety Net requires my written consent in order to bill any third-party payers for any services I receive at a 42 CFR Part 2 Program. I authorize Safety Net Outpatient Treatment Program to release information and my medical records to my healthcare Insurer for purposes of supporting and substantiating claims related to the services received at Ritter Center Safety Net. This authorization is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this authorization will terminate upon: _____ **Date/Event (End of my services at Safety Net Outpatient Treatment Program, if left blank)**

_____ _____

Client Signature Date

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Client Rights and Responsibilities

PURPOSE: To assure basic rights of clients and to preserve independent expression and decision-making.

AS A CLIENT I HAVE A RIGHT TO:

1. Treatment without discrimination as to race, color, religion, sexual orientation, national origin, age, disability, or status as a disabled veteran.
2. Care that is considerate and respectful.
3. Participation in decisions regarding treatment.
4. The name and function of or persons providing services and the identity of other personnel and institutions assisting in treatment.
5. Complete and current information concerning your diagnosis, treatment, and expected outcome in terms you can be reasonably expected to understand.
6. Receive information regarding condition/treatment options.
7. Refuse treatment and to be informed of any potential consequences.
8. Privacy to the extent consistent with care.
9. Confidentiality of all records pertaining to your treatment, except as otherwise provided as law.
10. Continuity of care and to be informed of the possibility of continuing requirements following the end of treatment.
11. Refuse to participate in research.
12. Examine and receive an itemized statement of all charges.
13. Upon request, full disclosure of facilities rules and regulations.
14. A smoke free environment.

I HAVE THR RESPONSIBILITY FOR:

1. Providing, to the best of my knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to my health. I must also reports unexpected changes in my condition to the responsible program staff.
2. Making it known whether or not I clearly understand a contemplated course of treatment or prevention curriculum and expectations.
3. Following the treatment plan recommended including completing my agreed upon goals before successful completion of the program.
4. Keeping appointments and for notifying the proper persons if unable to do so. I also understand that I am responsible for my own actions and for the consequences of my actions.
5. Provide urine samples for the purposes of laboratory analysis upon request from clinical staff. I understand that the results of these tests will be incorporated into my medical record.

Assuring that the financial obligations of my care are fulfilled as soon as possible.

1. Following facility rules affecting my care, conduct and safety (including non-violent behavior, abstinence from drugs and/or alcohol, outside meeting attendance.)

2. For being considerate of the rights of others and for assisting in the control of noise and regarding the smoking policy.

3. To attend meetings and other sessions and complete program assignments and activities defined by my treatment plan.

I have read this form or had it explained to me and I understand its contents. I have been offered a copy of this form.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Notice of Privacy/Confidentiality Practices – Acknowledgement of Receipt

Client Name: _____ Date: _____

By signing this form, you acknowledge that Ritter Center Safety Net Outpatient Treatment Program has given you a copy of its Privacy/Confidentiality Practices Notice, which explains how your health information will be handled in various situations.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

□ I have received the Ritter Center Safety Net Outpatient Programs Privacy Notice.

□ I have been given the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____

Clients Signature Date

Consent to Use FreedAI Scribe for Mental Health and Medical Services

Client/Patient Name: _____
Date: _____

1. Purpose of Consent

This form is to obtain your informed consent to use **FreedAI Scribe**, an AI-powered documentation tool, during your medical and/or mental health sessions. FreedAI Scribe helps providers by transcribing, summarizing, and organizing clinical notes securely and efficiently.

2. Privacy and Confidentiality

- Your privacy is a top priority. FreedAI Scribe and your provider will handle your information with strict confidentiality.
- Only authorized personnel will have access to any notes generated using FreedAI Scribe.

3. Use and Storage of Information

- FreedAI Scribe's secure systems may process the audio and/or transcriptions.
- No recordings or transcriptions will be stored permanently. Recordings are transcribed and deleted within 1-2 minutes following the appointment.
- FreedAI Scribe is designed to comply with applicable data privacy regulations, including HIPAA.

4. Benefits

- Improved accuracy and efficiency in documentation
- Enhanced continuity and quality of care (Provider can focus on you)

5. Risks and Limitations

- As with any technology, there is a minimal risk of data breach or error, although FreedAI Scribe employs industry-standard encryption and security measures.

6. Your Rights

- You may decline or withdraw your consent to the use of FreedAI Scribe at any time without affecting your access to care.

Consent

☐ I have read and understood the information above.
☐ I have had the opportunity to ask questions, and they were answered to my satisfaction.
☐ I voluntarily consent to the use of FreedAI Scribe during my mental health and/or medical appointments.

Signature of Client/Patient: _____

Date: _____

Ritter Center Safety Net Treatment Program

Consent to Follow Up

I, _____, give my consent to the Ritter Center Safety Net Outpatient and its authorized personnel to conduct a follow up interview or survey on my status within one year from the date of my discharge from the Safety Net Outpatient Program. The consent shall expire one year from the date of discharge. The follow-up will be used to evaluate my progress. I may also choose to re-enroll in the program if appropriate. I understand that the information collected will be kept confidential.

How do you prefer that we contact you? Please check all that apply.

□ Telephone

- What is the best number to contact you? _____

- Is there a time of day more convenient for us to contact you? _____

- Is it ok to leave a message if you are not available? _____

□ Email – What is the best email address to contact you? _____

□ Mail – What is the best mailing address to contact you? _____

□ In-Person

□ Other: _____

Acknowledgement

By signing this document, I acknowledge that I understand that I am consenting to be contacted after participating in the program and that individual-level information collected will be kept confidential. This consent is not required to participate in the program.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

PLEASE STOP AT THIS POINT. COUNSELOR WILL HELP YOU FROM HERE.

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Consent for Release of Information

Emergency Contact

Client Name: _____ DOB: _____

From Whom: The Ritter Center Safety Net Program
(NAME OF PROGRAM MAKING DISCLOSURE)

To Whom: _____
(NAME OF PERSON/S or ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE)

Address: _____

Phone:_____ Fax: _____ E-Mail:_____

What Kind and How Much: I authorize Safety Net to disclose the following information. (Check all that apply. If you only want part of a line included but not all of it, cross out what you do not want.)

YES NO

☐ ☐ 1. Medical History, examinations, laboratory tests and treatment reports.

☐ ☐ 2. Psychological test, psychiatric evaluation, neurological workup.

☐ ☐ 3. Social History, including family, education, employment, legal and drug use information.

☐ ☐ 4. Summary of substance abuse treatment.

☐ ☐ 5. Summary of mental health treatment.

☐ ☐ 6. Periodic reports or current treatment progress including attendance, and participation.

☐ ☐ 7. Discharge and aftercare planning.

☐ ☐ 8. TB test and/or chest x-ray results.

☐ ☐ 9. Specify any other documentation requested: _____

Purpose: I understand that this information will be used for the following purpose(s): (check all that apply)

☐ 1. To develop a diagnosis, treatment, and rehabilitation plan.

☐ 2. To coordinate medical, psychological, and social rehabilitative process.

☐ 3. To process insurance claims (diagnosis, number of visits, modalities, and expected length of stay.

☐ 4. Specify any other purpose:_____

This Consent Expires: (check one)

☐ **12 Months from the Date Signed, or 90 days after discharge (if under one year)**

☐ **Other date, event, or condition (specify):**_____

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Consent for Release of Information

Emergency Contact

Form(s) - in which information may be released/exchanged: ☐ Verbal ☐ Written ☐ Electronic ☐ Fax

Right to Revoke – You may revoke (cancel) this consent at any time. Your cancellation will be effective when we receive your request, except to the extent that disclosures have already been made based on your consent.

Right to Refuse to Sign This Consent – You may refuse to sign this consent. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

Right to Receive a Copy - You have a right to receive a copy of this consent and a right to see and obtain a copy of the personal health information being disclosed.

Federal Restrictions to Privacy: Your records are protected by Federal Regulations governing the confidentiality of Alcohol and Drug Abuse Client Records, 42-CFR, Part 2 and no information may be re-disclosed by either party to any other individual or agency unless by your written consent.

I have reviewed and understand the content of this consent form. By signing this consent, I am confirming it accurately reflects my wishes.

_____

(Date) (Signature of Client)

_____

(Date) (Print Name) (Signature of Guardian or Authorized Rep when required)

A copy of this consent has been offered to me. _____ **Accepted** _____ **Rejected**

This section is to be completed only if the client wishes to cancel the consent after it has been implemented.

<u>Revocation of Consent</u>:

I would like to revoke this consent: Signature _____Date_____

Staff witness: Signature _____Date_____

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Consent for Release of Information

Funding/Billing

Client Name: _____ DOB: _____

From Whom: The Ritter Center Safety Net Program
(NAME OF PROGRAM MAKING DISCLOSURE)

To Whom: Department of Health Care Services Medi-Cal
(NAME OF PERSON/S or ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE)

Address: 1700 K St. Sacramento, CA 95811

Phone: 800-879-2772 Fax: N/A E-Mail: N/A

What Kind and How Much: I authorize Safety Net to disclose the following information. (Check all that apply. If you only want part of a line included but not all of it, cross out what you do not want.)

YES NO

☐ ☐ 1. Medical History, examinations, laboratory tests and treatment reports.

☐ ☐ 2. Psychological test, psychiatric evaluation, neurological workup.

☐ ☐ 3. Social History, including family, education, employment, legal and drug use information.

☐ ☐ 4. Summary of substance abuse treatment.

☐ ☐ 5. Summary of mental health treatment.

☐ ☐ 6. Periodic reports or current treatment progress including attendance, and participation.

☐ ☐ 7. Discharge and aftercare planning.

☐ ☐ 8. TB test and/or chest x-ray results.

☐ ☐ 9. Specify any other documentation requested: _____

Purpose: I understand that this information will be used for the following purpose(s): (check all that apply)

☐ 1. To develop a diagnosis, treatment, and rehabilitation plan.

☐ 2. To coordinate medical, psychological, and social rehabilitative process.

☐ 3. To process insurance claims (diagnosis, number of visits, modalities, and expected length of stay.

☐ 4. Specify any other purpose:_____

This Consent Expires: (check one)

☐ **12 Months from the Date Signed, or 90 days after discharge (if under one year)**

☐ **Other date, event, or condition (specify):**_____

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Consent for Release of Information

Funding/Billing

Form(s) - in which information may be released/exchanged: ☐ Verbal ☐ Written ☐ Electronic ☐ Fax

Right to Revoke – You may revoke (cancel) this consent at any time. Your cancellation will be effective when we receive your request, except to the extent that disclosures have already been made based on your consent.

Right to Refuse to Sign This Consent – You may refuse to sign this consent. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

Right to Receive a Copy - You have a right to receive a copy of this consent and a right to see and obtain a copy of the personal health information being disclosed.

Federal Restrictions to Privacy: Your records are protected by Federal Regulations governing the confidentiality of Alcohol and Drug Abuse Client Records, 42-CFR, Part 2 and no information may be re-disclosed by either party to any other individual or agency unless by your written consent.

I have reviewed and understand the content of this consent form. By signing this consent, I am confirming it accurately reflects my wishes.

_____

(Date) (Signature of Client)

_____

(Date) (Print Name) (Signature of Guardian or Authorized Rep when required)

A copy of this consent has been offered to me. _____ **Accepted** _____ **Rejected**

This section is to be completed only if the client wishes to cancel the consent after it has been implemented.

<u>Revocation of Consent</u>:

I would like to revoke this consent: Signature _____Date_____

Staff witness: Signature _____Date_____

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Consent for Release of Information

General Consent

Client Name: _____ DOB: _____

From Whom: The Ritter Center Safety Net Program
(NAME OF PROGRAM MAKING DISCLOSURE)

To Whom: **Quest Diagnostics**
(NAME OF PERSON/S or ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE)

Address: **500 Plaza Drive, Secaucus, NJ 07094, USA**

Phone: 1 (866) 697-8378 Fax: N/A E-Mail: QuestExperience@questdiagnostics.com

What Kind and How Much: I authorize Safety Net to disclose the following information. (Check all that apply. If you only want part of a line included but not all of it, cross out what you do not want.)

YES NO

☐ ☐ 1. Medical History, examinations, laboratory tests and treatment reports.

☐ ☐ 2. Psychological test, psychiatric evaluation, neurological workup.

☐ ☐ 3. Social History, including family, education, employment, legal and drug use information.

☐ ☐ 4. Summary of substance abuse treatment.

☐ ☐ 5. Summary of mental health treatment.

☐ ☐ 6. Periodic reports or current treatment progress including attendance, and participation.

☐ ☐ 7. Discharge and aftercare planning.

☐ ☐ 8. TB test and/or chest x-ray results.

☐ ☐ 9. Specify any other documentation requested: Insurance Information

Purpose: I understand that this information will be used for the following purpose(s): (check all that apply)

☐ 1. To develop a diagnosis, treatment, and rehabilitation plan.

☐ 2. To coordinate medical, psychological, and social rehabilitative process.

☐ 3. To process insurance claims (diagnosis, number of visits, modalities, and expected length of stay.

☐ 4. Specify any other purpose:_____

This Consent Expires: (check one)

☐ **12 Months from the Date Signed, or 90 days after discharge (if under one year)**

☐ **Other date, event, or condition (specify):**_____

Form(s) - in which information may be released/exchanged: ☐ Verbal ☐ Written ☐ Electronic ☐ Fax

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Consent for Release of Information

General Consent

Right to Revoke – You may revoke (cancel) this consent at any time. Your cancellation will be effective when we receive your request, except to the extent that disclosures have already been made based on your consent.

Right to Refuse to Sign This Consent – You may refuse to sign this consent. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

Right to Receive a Copy - You have a right to receive a copy of this consent and a right to see and obtain a copy of the personal health information being disclosed.

Federal Restrictions to Privacy: Your records are protected by Federal Regulations governing the confidentiality of Alcohol and Drug Abuse Client Records, 42-CFR, Part 2 and no information may be re-disclosed by either party to any other individual or agency unless by your written consent.

I have reviewed and understand the content of this consent form. By signing this consent, I am confirming it accurately reflects my wishes.

_____

(Date) (Signature of Client)

_____

(Date) (Print Name) (Signature of Guardian or Authorized Rep when required)

A copy of this consent has been offered to me. _____ **Accepted** _____ **Rejected**

This section is to be completed only if the client wishes to cancel the consent after it has been implemented.

<u>Revocation of Consent</u>:

I would like to revoke this consent: Signature _____Date_____

Staff witness: Signature _____Date_____

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Consent for Release of Information

General Consent

Client Name: _____ DOB: _____

From Whom: The Ritter Center Safety Net Program
(NAME OF PROGRAM MAKING DISCLOSURE)

To Whom: _____
(NAME OF PERSON/S or ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE)

Address: _____

Phone:_____ Fax: _____ E-Mail:_____

What Kind and How Much: I authorize Safety Net to disclose the following information. (Check all that apply. If you only want part of a line included but not all of it, cross out what you do not want.)

YES NO

☐ ☐ 1. Medical History, examinations, laboratory tests and treatment reports.

☐ ☐ 2. Psychological test, psychiatric evaluation, neurological workup.

☐ ☐ 3. Social History, including family, education, employment, legal and drug use information.

☐ ☐ 4. Summary of substance abuse treatment.

☐ ☐ 5. Summary of mental health treatment.

☐ ☐ 6. Periodic reports or current treatment progress including attendance, and participation.

☐ ☐ 7. Discharge and aftercare planning.

☐ ☐ 8. TB test and/or chest x-ray results.

☐ ☐ 9. Specify any other documentation requested: _____

Purpose: I understand that this information will be used for the following purpose(s): (check all that apply)

☐ 1. To develop a diagnosis, treatment, and rehabilitation plan.

☐ 2. To coordinate medical, psychological, and social rehabilitative process.

☐ 3. To process insurance claims (diagnosis, number of visits, modalities, and expected length of stay.

☐ 4. Specify any other purpose:_____

This Consent Expires: (check one)

☐ **12 Months from the Date Signed, or 90 days after discharge (if under one year)**

☐ **Other date, event, or condition (specify):**_____

Form(s) - in which information may be released/exchanged: ☐ Verbal ☐ Written ☐ Electronic ☐ Fax

ritter center
health, home & community

Consent for Release of Information

General Consent

Right to Revoke – You may revoke (cancel) this consent at any time. Your cancellation will be effective when we receive your request, except to the extent that disclosures have already been made based on your consent.

Right to Refuse to Sign This Consent – You may refuse to sign this consent. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

Right to Receive a Copy - You have a right to receive a copy of this consent and a right to see and obtain a copy of the personal health information being disclosed.

Federal Restrictions to Privacy: Your records are protected by Federal Regulations governing the confidentiality of Alcohol and Drug Abuse Client Records, 42-CFR, Part 2 and no information may be re-disclosed by either party to any other individual or agency unless by your written consent.

I have reviewed and understand the content of this consent form. By signing this consent, I am confirming it accurately reflects my wishes.

_____

(Date) (Signature of Client)

_____

(Date) (Print Name) (Signature of Guardian or Authorized Rep when required)

A copy of this consent has been offered to me. _____ **Accepted** _____ **Rejected**

This section is to be completed only if the client wishes to cancel the consent after it has been implemented.

<u>Revocation of Consent</u>:

I would like to revoke this consent: Signature _____Date_____

Staff witness: Signature _____Date_____