Breaking Through:
A Clinical & Consulting Firm, Inc.

CLIENT INFORMATION SHEET

Office Use Only:
MCO/Payor: **Therapist:** Zynasia Jasper, MS, NCC, LPC **Location:**

Today's date:		Record #	

PATIENT INFORMATION (PLEASE PRINT)

Patient's Last Name: First: Middle: Maiden:	❑ Miss ❑ Ms. ❑ Mrs ❑ Mr.	Client Lives In Legal Guardian's Household (circle one) Yes / No

Client Adopted? ❑ Yes ❑ No	Social Security no.:	Home Phone no: ( )	Birth date:	Age:	Gender Expression: ❑ M ❑ F

Race: Please check one	❑ White/Caucasian	❑ Black/African American	❑ Hispanic/Latin	❑ American Indian	❑ Asian	❑ Other _____

Legal Guardian Name and Relationship to client:	Email Address:	Cell Phone no: ( )
Foster Parent(s) Name:	Foster Parent(s) Email Address:	Foster Parent(s) Cell Phone No.: ( )

Street address:

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

How did you hear about us? (please check one):	❑ Dr. _____ ❑ Sovah Healthcare ❑ Centra Healthcare ❑ Other	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Foster Care Agency	❑ Internet Search	❑ Community Services Board	❑ Other

Other family members seen here:

Annual Income Range:	❑ Less than 5,000	❑ 5,000-9,999	❑ 10,000-14,999	❑ 15,000-24,999	❑ 25,000-34,999	❑ 35,000 or more

Primary Language:	Known Allergies:	Spiritual Orientation:

Primary Care Physician:	Tel #:

INSURANCE INFORMATION

Type of Insurance:	Policy #:	Medicaid #:	

Please give your insurance card to the receptionist.

IN CASE OF EMERGENCY (PLEASE PRINT)

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Breaking Through: A Clinical & Consulting Firm, Inc. or insurance company to release any information required to process my claims.

X		X
Patient/Guardian signature		*Date*
X		X
Client signature		*Date*

Client Name: Medicaid #: DOB: Record #:

Notification of Agency Policies

Below you will see a brief review of numerous policies/agreements adopted by Breaking Through: A Clinical & Consulting Firm, Inc. in order to assure the safety of the families we serve and all of our staff. If you wish to see the full policy/agreement, please request such from staff.

TOBACCO FREE CAMPUS POLICY: It is the policy of Breaking Through: A Clinical & Consulting Firm, Inc. that all clients receiving campus-based services are not permitted to smoke or use any tobacco products while under the care and supervision of Breaking Through: A Clinical & Consulting Firm, Inc. staff (e.g. buildings, grounds, vehicles and outings).

BEHAVIOR MANAGEMENT POLICY: It is the policy of Breaking Through: A Clinical & Consulting Firm, Inc. that all staff will strive to create a safe, nurturing and non-coercive environment for children and families. Therefore, it is the duty of every staff member to insure the safety of every child entrusted to our care. Staff shall employ only those behavior management techniques, which are in accordance with Breaking Through: A Clinical & Consulting Firm, Inc.'s procedure. Corporal punishment, coercive actions and/or undue force of any kind are prohibited.

WEAPONS FREE CAMPUS POLICY: It is the intention of Breaking Through: A Clinical & Consulting Firm, Inc. to provide a safe and caring atmosphere for our youth, families, and staff. In order to accomplish this, it is Breaking Through: A Clinical & Consulting Firm, Inc. policy that no client possesses any item that is considered to be a "dangerous weapon." Such items include, but are not restricted to: knives, explosives, pepper spray, clubs, guns, etc. If such weapons are found to be in the possession of any client or if any item is being handled with intent to harm or threaten harm, staff shall follow the procedures for securing the area and confiscating the weapon.

CLIENT RIGHTS POLICY: It is the policy of Breaking Through: A Clinical & Consulting Firm, Inc. that all clients are afforded certain rights and a copy of these Client Rights is made available to them by the program staff. In addition, these rights are posted in each program area.

DISCHARGE PLANNING AGREEMENT: Clinicians will begin discharge planning at admissions as noted in the client's plan. Effective transition from Breaking Through: A Clinical & Consulting Firm, Inc. is essential for sustained improvement/ Transition plans may include: group and/or family therapy, attendance of self-help groups, ongoing pursuit of interests such as sports, music, and mentoring programs.

It is our hope that together we can help you accomplish your goals. However, there are times when issues arise that may make it difficult for us to continue working together. If you, as a family/an individual, have not participated actively in the therapeutic relationship (i.e.-attending sessions consistently), your placement with our organization could be jeopardized. Likewise, it could be determined that the services provided within our organization are not the best available option for you and/or your family. If, at any time, you do not feel like our services are meeting your family's needs, please be in touch with your Case Manager to address your concerns.

As part of the our desire to make sure your family accomplishes the established goals while in treatment, we may be in contact with your family post-discharge to inquire about continued progress.

I have read the above statements of policy/agreements at Breaking Through: A Clinical & Consulting Firm, Inc. I have been given the opportunity to ask questions about stated policies/agreements. I further agree to follow stated policies/agreements.

_____ Date: _____
Client Signature

_____ Date: _____
Parent/Legal Guardian Signature

_____ Date: _____
Staff Witness

Breaking Through: A Clinical & Consulting Firm, Inc. 177 Riverview Drive, Upper Level, Danville, VA 24541
434.227.3909 (telephone) 434.333.7014 (fax)

Client Name: Medicaid #: DOB: Record #:

INITIAL	Multi Use Consent
_____ _____	**CONSENT FOR TREATMENT**: I have been informed of and agree to the services provided by Breaking Through: A Clinical & Consulting Firm, Inc. which are outlined in the treatment plan. I agree to these services for: ____Myself _____ My child _____ The person for whom I am the Legal Guardian/Custodian Unless I have been court ordered to attend this service, I understand that my participation is voluntary and I may withdraw from treatment at any time. If I do not withdraw this consent, it shall be valid for the entire length of my treatment.
_____ _____	CONSUMER HANDBOOK reviews topics such as our values and beliefs regarding working together, videotaping, privacy & confidentiality, grievance process, appointments, adult conversations, client rights and fee assessment and collection. I acknowledge receiving, reviewing & having the opportunity to ask questions about this handbook including the Notice of Information Practices (effective April 14, 2003).
_____ _____	CONSENT FOR EMERGENCY CARE: I authorize Breaking Through: A Clinical & Consulting Firm, Inc. to provide CPR and First Aid attention if deemed necessary, Please identify which hospital preference is preferred: _____
_____ _____	CONFIDENTIALITY AND DISCLOSURE OF INFORMATION: In accordance with state and federal laws, information maintained about you (the client) at this practice will be protected from unauthorized disclosure. No information will be sent out unless it is discussed with you ahead of time and your permission is obtained. Disclosure is permitted under state and federal laws for situations which may be applicable to you, such as: 1) In the interest of public safety (life threatening situations); 2) In response to a court order; and 3) Where state laws require that information be disclosed to the appropriate authorities (e.g. suspected abuse or neglect of children or disabled adults, communicable disease, etc). Client records relating to Substance Abuse are protected by more stringent Federal Confidentiality rules. Rules regarding disclosure of substance abuse information must be strictly followed. Consent forms must specify in writing what substance abuse information is being released. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ Date: _____
Client Signature

_____ Date: _____
Parent/Legal Guardian Signature

_____ Date: _____
Staff Witness

Client Name: Medicaid #: DOB: Record #:

FINANCIAL RESPONSIBILITY FORM

Legal Guardian Printed Name: _____

Relationship to the Client: _____

Address: _____

City/State/Zip:

I certify that I am LEGAL GUARDIAN of the child listed above as indicated by the following documents:
(Birth certificate, court documents, etc) _____
*I have provided these documents to staff.

I will promptly notify Breaking Through: A Clinical & Consulting Firm, Inc. regarding any changes or proposed changes in my insurance coverage, address, place of employment, changes in income or custody status. Failure to notify the business office of such changes may result in my being held responsible for the full balance for any services provided.

I have been informed that there are different fees associated with the treatment at Breaking Through: A Clinical & Consulting Firm, Inc. These include:
Evaluation: $175.00/hr
Outpt: Initial: $130.00/session On-going: $130.00/session

I understand that most insurance companies, including Medicaid, DO NOT cover NO SHOW fees for outpatient services. If I cancel a session without providing my therapist a 24-hour notice, I can be charged a $25 fee.

I agree that I will be responsible for payment related to services received at Breaking Through: A Clinical & Consulting Firm, Inc. This could include co-payments, deductibles or fees associated with any program my child is enrolled in.

I authorize Breaking Through: A Clinical & Consulting Firm, Inc. to bill my insurance carrier for services provided by this agency. I will be responsible for any charges incurred as a result of failure to notify the business office of any change in insurance status (including changes in Medicaid coverage).

I authorize Breaking Through: A Clinical & Consulting Firm, Inc. to release information necessary to process insurance claims for services provided by this practice only. I authorize this office to apply for benefits on my behalf for covered services rendered and request that payment from my insurance company be made directly to Breaking Through: A Clinical & Consulting Firm, Inc. I understand that this authorization is valid for the duration of treatment unless I choose to revoke this authorization in writing. If I revoke this authorization, I understand that I can stop the release of information after the revocation letter is received by the business office, but cannot stop information that has already been released. I understand that if I revoke this authorization, I will be responsible for full payment of further treatment fees. Breaking Through: A Clinical & Consulting Firm, Inc. may utilize a collections procedure to collect on unpaid balances.

The co-payment that I am responsible for is $_____.

I will be invoiced monthly for any balance present on my account. I will contact the Finance department, Accounts Manager at 434.227.3909 if I am unable to maintain my payment arrangements. (*Staff: please attached completed Payment Arrangements Form)

_____ Date: _____
Parent/Legal Guardian Signature

_____ Date: _____
Breaking Through CCF Staff Representative

Client Name: Medicaid #: DOB: Record #:

BREAKING THROUGH: A CLINICAL & CONSULTING FIRM, INC.
FACILITIES USE AGREEMENT FOR CLIENTS, VISITORS, PARTICIPANTS AND/OR VOLUNTEERS
ACKNOWLEDGMENT OF RISK, ACCEPTANCE OF RESPONSIBILITY AND RELEASE/DISCHARGE FROM LIABILITY.

Please read and understand the entire document before initialing and signing the form. You or those in your care/custody or those you represent may not participate in any activities or use any facilities without this form being completed and signed.

I understand that the activity that I and the family or group I represent are about to voluntarily engage in as a client, visitor, participant, spectator and/or volunteer may bear certain known risks and unanticipated risks which could result in physical or emotional injury, damage to myself or others, to property or to spectators or to third parties. I understand that the risks simply **cannot be eliminated** without jeopardizing the essential qualities of the activity.

Being aware that this activity might entail risk of injury to me and /or the family or group I represent and/or risk of injury to spectators or other third parties as a result of my actions, I expressly agree, covenant and promise to accept and assume all responsibility and risk for injury or damage arising from my participation or the participation of my family or group in this activity. My participation and /or the participation of the family or group I represent in this activity is purely voluntary, no one is forcing me or us to participate, and I or we elect to participate in spite of the risks. I and /or the family or group I represent fully understand that I may elect to not participate in any given activity at any time.

ADDITIONAL TERMS

This facility is used by many different groups of people. Some of the people you or your group may encounter may be clients of Breaking Through: A Clinical & Consulting Firm, Inc. (BTCCF). We do not differentiate our clients from other BTCCF visitors. Therefore we request you and your group respect the privacy of any person you may encounter on the premises by not asking personal questions to them or about them. Please maintain the confidentiality of any person you see on the campus even after you complete this activity.

I have read this agreement and understand it. I and the family or group I represent agree to be bound by its terms. I have had all my questions answered regarding the activity I am about to engage in and will comply with the instructions for use. I and /or the family or group I represent hereby release, forever discharge and agree to indemnify and hold harmless Breaking Through: A Clinical & Consulting Firm, Inc., Inc., its agents or employees from any and all liability, claims, demands, or causes of action, which are in any way connected to my participation in the activity or my use of Breaking Through: A Clinical & Consulting Firm, Inc., Inc. equipment or facilities, including any such claims which allege negligent acts or omissions of Breaking Through: A Clinical & Consulting Firm, Inc.

Participant Signature _____Date_____

Parent/Guardian Signature: _____Date_____
(If under 18)

Relationship: _____

Agreed to: Breaking Through: A Clinical & Consulting Firm, Inc. by

Staff Signature: _____ Date: _____

Client Name: Medicaid #: DOB: Record #:

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of further

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records is stored off site.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

Client Name: Medicaid #: DOB: Record #:

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION.

_____ _____

Individual or Legal Representative (please print) Date

_____ _____

Signature of Individual or Legal Representative Date

Client Name: Medicaid #: DOB: Record #:

No Show, Late Cancellation and Co-payment Policy

At Breaking Through: A Clinical & Consulting Firm, Inc., we truly believe that each client's experience is unique and valuable. **Consistency and commitment** are among some of key components to a successful therapeutic relationship. Excessive cancellations, no-shows, and rescheduling can inhibit progression; additionally, time and resources are taken from other clients.

1. I understand that I will be charged a **LATE CANCELLATION** fee of **$25.00** if I fail to give at least 24-hour notice prior to canceling my appointment. **Initial: _____**

2. I understand that I will be charged a **NO-SHOW** fee of **$25.00** if I fail to show for my appointment. **Initial: _____**

3. I understand that if I cancel a session, the expectation is that I must reschedule a session within the same week if possible. **Initial: _____**

4. I understand that **THREE CANCELLATIONS &/or NO-SHOWS** *may result in a premature, unsuccessful* ***discharge*** from Breaking Through: A Clinical & Consulting Firm, Inc. or referral to another provider. **Initial: _____**

5. I understand that I am responsible for knowing my co-payment amount and deductible amount. My co-payment amount per session is _____; my deductible amount per year is _____. Have you met your deductible for this year? □YES □ NO If no, how much more do you have to pay towards your deductible?_____

6. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges. **Initial: _____**

7. I understand that the therapy session will last between **55-60 minutes**. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist. **Initial: _____**

_____
Signature of Responsible Party

_____
Date

Client Name: Medicaid #: DOB: Record #:

Patient Questionnaire

Name: _____
Date of Birth: _____ Age: _____

Medication Allergies:
_____
_____
_____

Current medications:
_____
_____
_____
_____
_____

Physician diagnosed medical problems:
_____
_____
_____

Past surgeries:
_____
_____

1. Does your _____Father _____Mother _____Brother(s) _____Sister(s) _____ Grandparents have a history of alcohol or drug abuse? _____
2. Do you smoke? _____ If yes, do you understand the need to stop use of all tobacco products immediately? _____
3. Do you use alcohol? _____ If yes, would you describe your use as --
   Minimal _____ Moderate _____ Heavy_____
4. Have you ever been treated or diagnosed with Alcoholism / Alcohol Abuse / Drug Addiction / Drug Abuse? _____
5. Do you think you are an alcoholic or a drug addict? _____
6. Have you abused prescription medications (your own or someone else's)? _____ Type?
   _____
   _____
7. Have you been convicted of any type of drug or alcohol related crime within the past 10 years?
   _____
   If yes, what was the charge and punishment (sentence) passed down?
   _____

8. What pharmacy will you be utilizing ?
   _____

9. Do you understand that providing non-functional or unreachable phone numbers &/or addresses will in all likelihood result in treatment discontinuation at this practice?
   _____
   Phone # _____ Cell # _____

10. Do you understand inappropriate/improper use of prescribed or non-prescribed medications may/will KILL YOU? YES _____ NO _____

11. Is it your statement that you have answered all questions and inquiries in a truthful and honorable manner? YES _____ NO _____

_____ _____
Signature **Date**

_____ _____
Parent/Guardian **Date**

_____ _____
Witness Signature **Date**

Client Name: Medicaid #: DOB: Record #:

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

By signing this form, I authorize Breaking Through: A Clinical & Consulting Firm, Inc. to obtain the following protected health information:

- ☐ Psychological Evaluations ☐ Psychiatric Evaluations ☐ Assessment/Admission Info
- ☐ Medical Records ☐ Immunization Records ☐ Progress Reports
- ☐ Educational Records (inc. IEP) ☐ Discharge Summary
- ☐ Service Documentation (i.e. Treatment Plan, Social History, CSB/MCO information)
- ☐ Other (be specific): _____

From: ___**Primary Care Physician**_____
(agency/individual from which information can be obtained)

Purpose for Obtaining Information: □ Treatment Planning □ Other (be specific): _____

By signing this form, I authorize Breaking Through: A Clinical & Consulting Firm, Inc. to release the following protected health information generated by Breaking Through: A Clinical & Consulting Firm, Inc.:

- ☐ Psychological Evaluations ☐ Psychiatric Evaluations ☐ Assessment/Admission Info
- ☐ Medical Records ☐ Immunization Records ☐ Progress Reports
- ☐ Educational Records ☐ Discharge Summary
- ☐ Service Documentation (i.e. Treatment Plan, Social History)
- ☐ Other (be specific): _____

To: _**Primary Care Physician**_____
(agency/individual to whom information can be released)

Purpose for Releasing Information: □ Treatment Planning □ Other (be specific): _____

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information (federal health privacy law, 45 C.F.R. parts 160, 164; the federal drug and alcohol confidentiality law, 42 C.F.R. part 2; and state confidentiality law governing mental health, developmental disabilities, and substance abuse services, G.S. 122C. Confidential information relative to a client with HIV infection, AIDS, or AIDS-related conditions shall only by released in accordance with N.C.G.S. § 130A-143.

I hereby acknowledge that this consent is truly voluntary and is valid for the time of application for service until the application is denied, until the child/client is discharged from the agency's program, or one year has elapsed. 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 these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law. I further understand that I may revoke this authorization at any time by sending notice of revocation in writing to the Privacy Officer (Director of Quality Improvement); however, I may not revoke this authorization to the extent that action has already been taken in reliance of this authorization.

NOTE: Randomly selected records are read by licensing personnel and peer reviewers for accrediting bodies. Also, detailed information including name, age, handicapping conditions, reasons for admission, purpose of placement, etc, is reported to the Duke Endowment for compiling statistics for agency and DSS use.

Client: _____
Signed Name Printed Name Date

Legal Guardian: _____
Signed Name Printed Name Date

Staff Witness: _____
Date

Breaking Through: A Clinical & Consulting Firm, Inc. 177 Riverview Drive, Upper Level, Danville, VA 24541
434.227.3909 (telephone) 434.333.7014 (fax)

Client Name: Medicaid #: DOB: Record #:

This consent expires 90 days from signature date for one-time releases or 12 months from signature date for ongoing releases.

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- ☐ Service Documentation (i.e. Treatment Plan, Social History, CSB/MCO information)
- ☐ Other (be specific): _____

From: **Danville City Schools/Pittsylvania County Schools**
(agency/individual from which information can be obtained)

Purpose for Obtaining Information: □ Treatment Planning □ Other (be specific): _____

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- ☐ Psychological Evaluations ☐ Psychiatric Evaluations ☐ Assessment/Admission Info
- ☐ Medical Records ☐ Immunization Records ☐ Progress Reports
- ☐ Educational Records ☐ Discharge Summary
- ☐ Service Documentation (i.e. Treatment Plan, Social History)
- ☐ Other (be specific): _____

To: **Danville City Schools/Pittsylvania County Schools**
(agency/individual to whom information can be released)

Purpose for Releasing Information: □ Treatment Planning □ Other (be specific): _____

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information (federal health privacy law, 45 C.F.R. parts 160, 164; the federal drug and alcohol confidentiality law, 42 C.F.R. part 2; and state confidentiality law governing mental health, developmental disabilities, and substance abuse services, G.S. 122C. Confidential information relative to a client with HIV infection, AIDS, or AIDS-related conditions shall only by released in accordance with N.C.G.S. § 130A-143.

I hereby acknowledge that this consent is truly voluntary and is valid for the time of application for service until the application is denied, until the child/client is discharged from the agency's program, or one year has elapsed. 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 these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law. I further understand that I may revoke this authorization at any time by sending notice of revocation in writing to the Privacy Officer (Director of Quality Improvement); however, I may not revoke this authorization to the extent that action has already been taken in reliance of this authorization.

NOTE: Randomly selected records are read by licensing personnel and peer reviewers for accrediting bodies. Also, detailed information including name, age, handicapping conditions, reasons for admission, purpose of placement, etc, is reported to the Duke Endowment for compiling statistics for agency and DSS use.

Client: _____
Signed Name Printed Name Date

Legal Guardian: _____
Signed Name Printed Name Date

Staff Witness: _____
Date

Breaking Through: A Clinical & Consulting Firm, Inc. 177 Riverview Drive, Upper Level, Danville, VA 24541
434.227.3909 (telephone) 434.333.7014 (fax)

Client Name: Medicaid #: DOB: Record #:

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- ☐ Educational Records (inc IEP) ☐ Discharge Summary
- ☐ Service Documentation (i.e. Treatment Plan, Social History, CSB/MCO information)
- ☐ Other (be specific): _____

From: ___**Insurance Provider-**_____

(agency/individual from which information can be obtained)

Purpose for Obtaining Information: □ Treatment Planning □ Other (be specific): _____

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- ☐ Psychological Evaluations ☐ Psychiatric Evaluations ☐ Assessment/Admission Info
- ☐ Medical Records ☐ Immunization Records ☐ Progress Reports
- ☐ Educational Records ☐ Discharge Summary
- ☐ Service Documentation (i.e. Treatment Plan, Social History)
- ☐ Other (be specific): _____

To: _**Insurance Provider-**_____

(agency/individual to whom information can be released)

Purpose for Releasing Information: □ Treatment Planning □ Other (be specific): _____

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information (federal health privacy law, 45 C.F.R. parts 160, 164; the federal drug and alcohol confidentiality law, 42 C.F.R. part 2; and state confidentiality law governing mental health, developmental disabilities, and substance abuse services, G.S. 122C. Confidential information relative to a client with HIV infection, AIDS, or AIDS-related conditions shall only by released in accordance with N.C.G.S. § 130A-143.

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Client: _____

Signed Name Printed Name Date

Legal Guardian: _____

Signed Name Printed Name Date

Staff Witness: _____

Date

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- ☐ Educational Records (inc IEP) ☐ Discharge Summary
- ☐ Service Documentation (i.e. Treatment Plan, Social History, CSB/MCO information)
- ☐ Other (be specific): _____

From: **Foster Care Agency-**_____
(agency/individual from which information can be obtained)

Purpose for Obtaining Information: □ Treatment Planning □ Other (be specific): _____

By signing this form, I authorize Breaking Through: A Clinical & Consulting Firm, Inc. to release the following protected health information generated by Breaking Through: A Clinical & Consulting Firm, Inc.:

- ☐ Psychological Evaluations ☐ Psychiatric Evaluations ☐ Assessment/Admission Info
- ☐ Medical Records ☐ Immunization Records ☐ Progress Reports
- ☐ Educational Records ☐ Discharge Summary
- ☐ Service Documentation (i.e. Treatment Plan, Social History)
- ☐ Other (be specific): _____

To: **Foster Care Agency-**_____
(agency/individual to whom information can be released)

Purpose for Releasing Information: □ Treatment Planning □ Other (be specific): _____

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information (federal health privacy law, 45 C.F.R. parts 160, 164; the federal drug and alcohol confidentiality law, 42 C.F.R. part 2; and state confidentiality law governing mental health, developmental disabilities, and substance abuse services, G.S. 122C. Confidential information relative to a client with HIV infection, AIDS, or AIDS-related conditions shall only by released in accordance with N.C.G.S. § 130A-143.

I hereby acknowledge that this consent is truly voluntary and is valid for the time of application for service until the application is denied, until the child/client is discharged from the agency's program, or one year has elapsed. 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 these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law. I further understand that I may revoke this authorization at any time by sending notice of revocation in writing to the Privacy Officer (Director of Quality Improvement); however, I may not revoke this authorization to the extent that action has already been taken in reliance of this authorization.

NOTE: Randomly selected records are read by licensing personnel and peer reviewers for accrediting bodies. Also, detailed information including name, age, handicapping conditions, reasons for admission, purpose of placement, etc, is reported to the Duke Endowment for compiling statistics for agency and DSS use.

Client: _____
Signed Name Printed Name Date

Legal Guardian: _____
Signed Name Printed Name Date

Staff Witness: _____
Date

Breaking Through: A Clinical & Consulting Firm, Inc. 177 Riverview Drive, Upper Level, Danville, VA 24541
434.227.3909 (telephone) 434.333.7014 (fax)

Client Name: Medicaid #: DOB: Record #:

This consent expires 90 days from signature date for one-time releases or 12 months from signature date for ongoing releases.

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

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- ☐ Educational Records (inc IEP) ☐ Discharge Summary
- ☐ Service Documentation (i.e. Treatment Plan, Social History, CSB/MCO information)
- ☐ Other (be specific): _____

From: **Department of Social Services-**
(agency/individual from which information can be obtained)

Purpose for Obtaining Information: □ Treatment Planning □ Other (be specific): _____

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To: **Department of Social Services-**
(agency/individual to whom information can be released)

Purpose for Releasing Information: □ Treatment Planning □ Other (be specific): _____

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