CLIENT IDENTIFICATION FACE SHEET

☐ Cardinal MCO	☐ Vaya MCO	☐ Partners MCO	**Record #:**
Full Name (Last, First, Middle: **Preferred name**:	**Street Address**: **City, State, Zip**:	**County of Residence**:	**Date**:
Maiden name (if applicable):	**Date of Birth**: **Age**:	**Home Phone**:	**Cell Phone**:
Gender:	**Race**:	**Ethnicity**:	**Referral Source**:
Primary Language:	**English Proficiency**: ☐ Yes ☐ No	**Educational Level**:	**Living Arrangements**:
Citizenship: ☐ Yes ☐ No	**SSN**:	**Veteran Status**:	**Competency Status**: ☐ Incompetent Minor/Adult
Allergies (if yes, explain): ☐ NKA Yes: **Advance Directive:** ☐ Yes ☐ No If Yes, Explain:	**Accommodations Needed**: ☐ None ☐ Deaf/Hearing Impaired ☐ Wheelchair/mobility needs ☐ Physical Disability ☐ Visually Impaired ☐ Intellectual Disability ☐ Sign Language/Interpreter ☐ Childcare ☐ Foreign Language Interpreter ☐ Frail Senior ☐ Assistive Technology needed ☐ Other:		**Client Employment Status**: ☐ Student ☐ Part Time ☐ Full Time ☐ Unemployed ☐ Not available for work
Medications: ☐ None ☐ Yes:	**Previous Treatment**: ☐ None ☐ Yes:	**Hospital Discharge in last 30 days**: ☐ Yes ☐ No	**# of Arrest in last 30 days:** ☐ None ☐ Yes:
Monthly Income: $	**Gross Annual Income: (Family):** $	**Number of people in household**:	**Proof of income**: ☐ Yes ☐ No
Legal Guardian: ☐ Own Guardian **Name**: **Relationship to client**: **Legal Documentation provided**? ☐ Yes ☐ No **Address**: ☐ Same as above **City/State/Zip**: **Phone Number**: **Email address**:		**Emergency Contact**: ☐ Legal Guardian is contact person **Name**: **Relationship to client**: **Phone #**: **Address**:	**Primary Care**: ☐ None **Name**: **Practice**: **Address**: **City/State/Zip**: **Phone**: **Dental Provider:** ☐ None **Name**: **Practice**: **Address**: **City/State/Zip**: **Phone**:
Insurance Information: ☐ None ☐ Medicaid ☐ Health Choice ☐ BCBS ☐ Aetna ☐ Tricare ☐ Ambetter ☐ State Funds ☐ Other:		**Health Plan Name**: **Effective Date**: **Policy #**: **Group #**: **Insured's name**: **Secondary Insurance**? ☐ None ☐ Yes, see below: **Health Plan Name**: **Effective Date**: **Policy #**: **Group #**: **Insured's name**:	

Client Name:	Date of Birth:	Record #:	Insurance #:	Date:

Turning Point Homes, LLC Corporate Office: 919 N. Main St. Ste. B, Mooresville NC 28115

TPH INTAKE DOCUMENTATION:

ADMISSION AGREEMENT/INFORMED CONSENT, ACKNOWLEDGEMENT OF RECEIPT OF CLIENT ORIENTATION HANDBOOK AND INFORMATION ON CLIENT RIGHTS AND NOTICES OF PRIVACY PRACTICES, & NOTIFICATION OF CLIENT FINANCIAL OBLIGATIONS

Please Select:

1. ☐ I hereby give consent for the above-named client to receive treatment from Turning Point Homes, LLC and in doing so agree to abide by the agency and program rules. I give consent for staff of Turning Point Homes, LLC to obtain emergency medical care as needed. I understand that this consent is valid for up to one year and can be withdrawn at any time.
2. ☐ I understand that the alleged benefit of treatment is improved quality of life and specific goals of treatment will be included in the individual service plan.
3. ☐ I understand that the potential risk of treatment is that treatment may uncover some uncomfortable feelings as blocks to growth are discovered. Working through those feelings will be an attempt to create greater self-awareness, greater self-trust, and an understanding that growth is an on-going process. If medication management services are chosen, there are additional risks associated with the use of medication.
4. ☐ I understand that there are alternative types of treatment available.
5. ☐ I agree to allow master-level students (interns) who are receiving training in such areas as mental health counseling, psychology, and social work under the direct supervision of a licensed professional to observe and participate in treatment.
6. ☐ I agree to allow Turning Point Homes' staff contact me via text, phone, or e-mail regarding services. I understand that e-mail is not encrypted; therefore, confidentiality cannot be guaranteed. I may revoke this permission at any time.
7. ☐ I hereby give consent for the above-named client to receive treatment from Turning Point Homes, LLC via tele health for on-going therapy and in doing so agree to abide by the agency and program rules.
8. ☐ I acknowledge that I have been given the opportunity to ask questions and inquire about services provided at Turning Point Homes, LLC and that my questions have been answered. I understand that this document may be amended on an as-needed basis and that any amendment will require my signature.

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I acknowledge receipt of the Turning Point Homes, LLC Client Orientation Handbook which contains the following information:

Listing of client rights	Notices of Privacy Practices
Access to crisis services	Rules and expectations regarding treatment, transition, and discharge
Agency policies and procedures	Client responsibilities

☐ I have been given an opportunity to ask questions to assist me in understanding privacy and other rights. I am satisfied with the explanation provided to me and am confident that Turning Point Homes, LLC is committed to protecting health information and client rights.

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Please Sign below to acknowledge the TPH Intake Documentation

Client Signature (required for SA):_____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Name:	Date of Birth:	Record #:	Insurance #:	Date:

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NOTIFICATION OF CLIENT FINANCIAL OBLIGATIONS

When you have been determined to be eligible for services, a financial assessment is made on your ability to pay. We accept Cardinal Innovations, Vaya Health, and Partners BHM Medicaid, NC Health Choice, BlueCross/BlueShield, United Health Care/United Behavioral Health, Aetna, Ambetter, and self-pay. Not all providers are eligible to provide services for all payment sources. For ongoing appointments, attempts will be made to schedule a private insurance client with their respective insurance covered provider. If paneled provider is not available, or you choose not to wait for an appointment with them, you may choose to pay out-of-pocket or be referred elsewhere.

For School Based Therapy clients, monies are not exchanged at schools between therapists and students. Therefore, for private insurance, private pay, IPRS, and Health Choice clients, your credit card information will be obtained at intake for the purpose of billing co-pays, services rendered, and in the event that your insurance fails to pay. Credit Card Payment Authorization Form will be reviewed and signed with you at intake.

Please Initial:

1. ☐ I/my child has insurance coverage through: _____
2. ☐ I understand that it is my responsibility to notify the business office immediately of any change in the above-named client's insurance coverage or benefits, or address or other contact information.
3. ☐ I have reviewed the TPH private insurance/private pay fee schedule and understand the out-of-pocket fees.
4. ☐ I have reviewed the sliding scale fee for IPRS/State Funding and understand my responsibility to pay, if any.
5. ☐ I authorize Turning Point Homes, LLC to bill my insurance for covered services rendered and request that payment from my insurance carrier be made directly to Turning Point Homes, LLC.
6. ☐ I understand that once three (3) unpaid visits/sessions is reached, I may be unable to schedule further appointments until efforts have been made to pay my outstanding balance.
7. ☐ I understand that I will be responsible to pay full private insurance rates until my deductible is met.
8. ☐ I understand that I will be responsible to pay any invoices received within thirty (30) of receiving the invoice from Billing Department.
9. ☐ I 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 has been received, but that I cannot stop information already released. I also understand that if I revoke this authorization, I will be responsible for full payment of further fees.

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Please Sign below to acknowledge the TPH Intake Documentation

Client Signature (required for SA):_____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Name:	Date of Birth:	Record #:	Insurance #:	Date:

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CLIENT AUTHORIZATION

To Permit Use and Disclosure of Protected Health Information

This authorization form implements the requirements for client authorization to use and disclose Health Information protected by the Federal Privacy Law, (HIPAA) 45 C.F.R. parts 160-164; the Federal Confidentiality Law, 42 C.F.R., part 2, and State Confidentiality Law governing Mental Health, Developmental Disabilities, and Substance Abuse Services G.S. 122C.

By signing this form, I authorize Turning Point Homes, LLC to send to and receive from (share information) the Protected Health Information indicated below (including HIV & Substance Abuse related information if applicable) with:

(Agency/Person): _____

Please indicate information to be disclosed by selecting:

☐ Admission/Screening Assessment
☐ Psychiatric Evaluation/Assessment
☐ Medication Hx/Physicians Orders
☐ Mental Health Records
☐ Substance Use Assessment/Treatment
☐ Treatment/Service Plan
☐ Treatment/Service Notes
☐ HIV Related Info.*
☐ Location & condition in the event of an emergency
☐ All pertinent information deemed necessary including HIV and Substance use information
☐ Discharge Information
☐ Demographic Information
☐ School Records

Purpose of disclosure: ☐Continuity of Care ☐Referral ☐ Service Delivery ☐ To notify in case of an emergency

Other: _____

*HIV or other communicable disease related information may be a part of multiple documents in the record

I understand that once information is disclosed pursuant to this authorization it is possible that it will not be protected by state and federal privacy and confidentiality laws and that it could be redisclosed by the person or agency that receives it.

*I understand that by indicating I authorize 3rd party information to be disclosed any Protected Health Information (PHI) from other treatment facilities contained in this medical record will be shared pursuant to this authorization, including substance use information.

I understand that with certain exceptions, I have the right to revoke this authorization at any time (orally or by submission of written notification). The procedure for revoking authorizations as well as the exceptions to my right to revoke is explained in Turning Point Homes Notice of Privacy Practices contained in the Client Orientation Handbook. If you do not have the TPH Client Orientation Handbook you may request one.

The meaning of this authorization form has been explained to me. I understand that I may refuse to sign this authorization form. I understand that Turning Point Homes will not condition treatment on receiving my signature on this authorization. I understand this authorization is made freely, voluntarily and without coercion. I understand the health information indicated will be disclosed per my instructions.

This authorization is effective for up to one year from today's date.

Client Signature (required for SA):_____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Name:	Date of Birth:	Record #:	Insurance #:	Date:

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CREDIT CARD PAYMENT AUTHORIZATION FORM

For School Based Therapy clients, monies are not exchanged at schools between therapists and students. Therefore, for private insurance/private pay clients, guardian's credit card information will be obtained at intake for the purpose of billing co-pays, services rendered, and in the event the client's insurance fails to pay.

You may Schedule weekly or monthly billing and authorize your payments to be automatically charged to your credit card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town)

Here's How Recurring Payments Work: You authorize regularly scheduled charges to your Visa, MasterCard, American Express and Discover. You will be charged each billing period for the total amount due for that period. A receipt will be emailed to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided if the total payment is under $100.00. If your bill is more than that amount, or the payment date changes, you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Turning Point Homes, LLC. to charge my credit card _____ (full name) indicated for payment of any related Counseling costs for _____ to include: Co-pay or billable amounts unpaid by insurance up to $100.00. I have read the Notification of Financial Obligation Form and understand the cost structure related to counseling services.

I understand that I will only receive advance notice of the charge if it will exceed $100.00.

I authorize payment (you must select one): ☐ Weekly ☐ Monthly

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____ CCV _____

SIGNATURE _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.