TURNING POINT BEHAVIORAL HEALTH SERVICES, LLC

CLIENT INFORMATION RECORD

PLEASE COMPLETE FORM IN IT'S ENTIRETY- PLEASE PRINT

NAME: _____ DOB: _____

SOCIAL SECURITY NUMBER: _____

STREET ADDRESS: _____

APT/UNIT NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMERGENCY PHONE: _____

MARITAL STATUS: _____ MALE/FEMALE: _____

PREGNANT: YES ☐ NO ☐ HOW MANY WEEKS: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU: _____

PHONE: _____ RELATIONSHIP: _____

WHO REFERRED YOU TO OUR OFFICE? _____

EMPLOYER: _____ POSITION: _____

I VERIFY THAT THIS INFORMATION IS CURRENT AND ACCURATE.

_____ _____

SIGNATURE DATE

TURNING POINT BEHAVIORAL HEALTH SERVICES, LLC

AUTHORIZATION TO OBTAIN AND RELEASE HEALTH CARE IFORMATION

Client Name: _____ Todays: Date: _____

Date of Birth: _____ SSN: _____

I request and authorize the following individual or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I receive to:

TURNING POINT BEHAVIORAL HEALTH SERVICES
2712 MIDDLEBURG ROAD, STE 219
Columbia, SC 29204
Phone: (803)-814-2607 Fax: (803)-814-2916

With the following individual or agency:

Primary Care Physician: _____
School Name: (if applicable) _____
Therapist: _____
Mental Health Facility: _____
Other: _____

The authorization for release and disclosure of medical information applies to: (check all that apply)

— Mental Health Evaluation/Treatment
— Previous Assessments
— Substance Abuse Information
— Psychological Reports
— Diagnosis on File
— Discharge Summary

Other information (please specify) _____

The information will be used/disclosed for the purpose of allowing clinically appropriate coordination of care.

This authorization expires when services are no longer being provided by TURNING POINT BEHAVIORAL HEALTH SERVICES or until I make written revocation of this authorization.

_____ _____

CLIENT SIGNATURE DATE

TURNING POINT BEHAVIORAL HEALTH SERVICES, LLC

PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by TURNING POINT BEHAVIORAL HEALTH SERVICES, LLC (hereinafter referred to as "TPBHS") for the purpose of diagnosis or providing treatment to *me,* obtaining payment for services rendered, or to conduct healthcare operations of TPBHS. I understand that diagnosis by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to conduct treatment, payment, or healthcare operations of the practice. TPBHS is not required to agree to the restrictions that I may request. However, if TPBHS agrees to the restriction I request, the restriction is binding.

I have the right to revoke this consent. in writing, at any time, except to the extent that TPBHS has acted in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by mv physician, another healthcare provider, health plan, mv employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review TPBHS Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in mv treatment, payment of my bills, or in the performance of healthcare operations of TPBHS. The Notice of Privacy Practices also describes my rights and T PBHS duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your express written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

TPBHS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

_____ _____

CLIENT SIGNATURE DATE

TURNING POINT BEHAVIORAL HEALTH SERVICES, LLC

TURNING POINT BEHAVIORALHEALTH SERVICES

I, _____ have been informed of the policies of TURNING POINT BEHAVIORAL HEALTH SERVICES regarding:

- Possession of tobacco
- The possession or use of illegal substances or misuse of legal substances
- The possession of any item which could be determined to be a weapon
- The possession of prescription medication
- The possession of weapons

when on the premises of any TURNING POIN T BEHAVIORAL HEALTH SERVICES property.

TURNING POINT BEHAVIORAL HEALTH SERVICES, LLC

CLIENT RIGHTS

TURNING POINT BEHAVIORAL HEALTH SERVICES every consumer has the right to the following:

- The right to receive information about TURNING POINT BEHAVIORAL HEALTH SERVICES, its services, its providers/practitioners, member rights and responsibilities presented in a manner appropriate to your ability to understand.
- The right to be treated with respect and recognition of your dignity and right to privacy.
- The right for services to be provided without humiliation.
- The right to receive care from neglect.
- The right to participate with providers/practitioners in making decisions regarding your healthcare.
- The right to a candid discussion with service providers/practitioners on appropriate medically necessary treatment options for your conditions, regardless of cost or benefit coverage. You may need to decide among relevant treatment options for the risks, benefits, and consequences, including your right to refuse treatment and to express your preferences about future treatment decisions regardless of benefits coverage limitation.
- The right to voice complaints or appeals about the organization or the care it provides.
- The right to make recommendations regarding the organization's member rights and responsibilities policy.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, or convenience of retaliation.
- The right to refuse treatment.
- The right to request and receive a copy of your medical record, subject to therapeutic privilege, and to request that the medical record be amended or corrected. If the doctor or therapist determines that this would be detrimental to your physical wellbeing, you can request that the information be sent to a physician or professional of your choice.
- If you disagree with what is written in your medical records, you have the right to write a statement to be placed in your file. However, the original notes will remain in the record until the statute of limitations ends according to the MH/DD/SA retention schedule.
- The right to participate in the development of a written person-centered treatment plan that builds on individual needs, strengths, and preferences. A treatment plan must be implemented within 30 days of starting services.
- The right to take part in the development and periodic review of your treatment plan and to consent to treatment goals in it.
- The right to freedom of speech and freedom of religious expression.
- The right to equal employment and educational opportunities.
- The right to treatment in the most natural, age appropriate and least restrictive environment possible.
- The right to ask questions when you do not understand your care or what you are expected to do.
- The right to have privileges removed/reinstated after a pre-established period, if applicable.

Client Name (Please Print): _____ Date: _____

Client Signature: _____

Witness Name (Please Print): _____ Date: _____

Witness Signature: _____

TURNING POINT BEHAVIORAL HEALTH SERVICES, LLC

FINANCIAL POLICIES

- We accept cash only for services.
- Full payment is due at the time of services.
- You are responsible for taking care of your financial obligations at each visit.

I have read and understand the policies above and agree to abide by them. I understand that I am financially responsible for payment for all services at the time services are rendered.

_____ _____

CLIENT SIGNATURE Date

Consumer Full Name:	Record Number:
Date of Birth:	Medicaid Number:

TURNING POINT BEHAVIORAL HEALTH SERVICES LLC

CONSENT TO DISCLOSE INFORMATION FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I authorize Turning Point Behavioral Health Services LLC to release any medical clinical health information necessary in the processing of claims for payment of services. This may include Social Security Health Care Financing Administration or its intermediaries or carriers Division of medical Assistance and its claim processor (Medicaid, Medicare), commercial insurance carriers, departments of social services, area mental health centers, and any other third-party payer the consumer responsible party may authorize. Data will include consumer name, dates of service, diagnosis, name of person providing services and any relevant charges. Other health information may include any alcohol, drug, or HIV/AIDS related. This information will be used to process payment claims only. This consent may be revoked within (30) days of the request for revocation being completed by the consumer.

I consent the release of protected health information:

Third Party Payers:

- Medicaid
- Medicare
- SC Health
- Other

I authorize payment by the third-party payers, listed above, to be paid directly to Turning Point Behavioral Health Services LLC for services rendered.

Consumer Name: _____ Effective Date: _____

Signature: _____ Date: _____

Witness Signature: _____

* *Valid for (2) years from effective date*

CANCELLATION AND NO SHOW

POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide 24-hour notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24-hour notice. We are unable to offer that slot to other clients.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$45.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered a **NO SHOW.** Patients may also be subject to a **$45.00** fee for an office appointment NO SHOW.

The **NO SHOW** fee is the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours.

Fees in this instance may be waived but only with approval.

Please sign that you have read, understand, and agree to this Cancellation and No-show policy.

Patient Name (Please Print)

_____

Signature of Patient or Patient Representative

_____

Date

_____