BERKELEY COMMUNITY MENTAL HEALTH CENTER
PATIENT EMERGENCY INFORMATION

In an effort to better serve you, please help us by providing us with the following information.

Patient's Name: _____ **Today's Date:** _____

Patient's Birth Date: _____ **Patient's Social Security Number:** _____

Patient's Phone Number(s): Home: _____ Cell: _____ Work: _____

Patient's Physical Address: _____

Patient's Mailing Address: _____
(if different from above)

Patient's Email Address: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ **Relationship:** _____

Address: _____ **Telephone Number(s):** _____

INSURANCE INFORMATION: (Please check all that apply and provide card(s) for copy)
___None (Please provide proof of income) ___Medicaid ___Medicare ___Private Insurance

_____

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed **Race:** _____

Military: _____ Current _____ Past **Branch of Military:** _____

Family Size: _____ **How many children does the patient have?** _____

Registered Voter? _____ Yes _____ No but _____ Would like to register to vote
_____ Would **Not** like to register to vote

Highest Grade of School Completed: _____

Primary Care Physician (Name, Address and Phone Number): _____

_____

May we contact you by phone, text, and/or email for appointment reminders?

I hereby give Berkeley Community Mental Health Center permission to send appointment reminder messages to me via phone, email and/or text messaging. **Please initial:** _____

(CHILDREN ONLY) Name of School Attending: _____ Current Grade: _____

Thank you for choosing Berkeley Community Mental Health Center. **CID:** _____

EXHIBIT # UN-53
COMMUNITY MENTAL HEALTH CENTER
DETERMINATION OF ABILITY TO PAY REDUCTION

Client _____ CID _____ Guarantor of payment if other than client _____

SS#:_____ Date of Birth:_____ Prepared by:_____

Address:_____ Telephone #:_____

INCOME	CURRENT	UPDATE
Self	$	$
Spouse/ Household	$	$
Public Assistance (list each type)*	$	$
	$	$
Alimony/Child Support	$	$
Other (list each)**	$	$
	$	$
GROSS INCOME:	$	$

EXTRAORDINARY EXPENSE	CURRENT	UPDATE
Medical	$	$
Alimony/Child Support	$	$
Other Non-Discretionary (list each)***	$	$
	$	$
	$	$
	$	$
	$	$
GROSS EXPENSES:	$	$

GROSS INCOME	LESS GROSS EXPENSES	EQUALS ADJUSTED GROSS INCOME	NUMBER IN HOUSHOLD

* List each type of public assistance, such as food stamps, AFDC, etc.
** For other recent income, other liquid assets or funds available for payment of medical bills including bank accounts, assets accumulated from public benefit payments, trust, etc.
*** For recent non-recurring expenses, medical expenses, etc.

OTHER RESPONSIBLE PARTY **PARENT/GUARDIAN/OTHER**

I do hereby certify that I accept responsibility for all charges for services provided to the above client.

_____ **Date:** _____ **SSN:** _____

Responsible Individual's Signature **Responsible Individual's Social Security Number**

I ACKNOWLEDGE THAT THE INFORMATION GIVEN IS ACCURATE AND COMPLETE AND THAT I WILL UPDATE THE INFORMATION AS IT AFFECTS MY ABILITY TO PAY. YOU MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALITIES IF YOU GIVE FALSE OR INCOMPLETE INFORMATION.

I AUTHORIZE ANY ENTITY HOLDING FINANCIAL RECORDS OR OTHER INFORMATION IN ANY FORM PERTAINING TO THE FINANCIAL INFORMATION GIVEN BY ME ABOVE TO DISCLOSE TOT HE CENTER ANY FINANCIAL INFORMATION NECESSARY FOR THE CENTER TO DETERMINE MY ELIGIBILITY, IF ANY, FOR A REDUCTION ON MY BILL.

I have been given a completed copy of this form and understand that I may request a review of my ability to pay at any time. This information may be updated at any time but must be reviewed at least annually.

_____ _____ _____
Client Signature Date (if applicable) Guarantor

_____ _____ _____
Client Signature (Update) Date (Updated) Date

REV: BCMHC 9/06/07

IF A US FEDERAL INCOME TAX RETURN HAS NOT BEEN FILED FOR THE PREVIOUS CLAENDAR YEAR AND/OR WILL NOT BE FILED FOR THE CURRENT YEAR, I DO HEARBY SWEAR THAT MY ANNUAL INCOME IS BELOW THE LEGAL LIMIT FOR FILING FOR LAST YEAR AND IS ANTICIPATED TO REMAIN BELOW THE LEGAL LIMITS THIS CURRENT YEAR.

_____ _____

Client Signature Date

Third party payors:

_____

_____

_____

I do hereby certify that I have no third party capability; therefore I am responsible for all charges for services provided to me.

_____ _____

Client Signature Date

I do hereby certify that I accept responsibility for all charges provided to the above client

_____ _____

Responsible Individual Signature Date

Demographic Information

Sex: Race: White African/American Spanish/American Asian/American American Indian Other

Marital Status: Single Married Divorced Widowed Separated Unknown Other

Grade in School:_____

School:_____

Legal Guardian:_____

MEDICAL RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process **Medicare, Medicaid, Champus/VA, or Private insurance** claims for _____ for services provided to
(Client's Name)

them with a starting date of _____ and request payment of benefits to:
(Admission Date/Update)

BERKELEY COMMUNITY MENTAL HEALTH CENTER
P.O. BOX 1030
MONCKS CORNER, SC 29461

_____ _____

Client's Signature (authorized person) Witness

REV: BCMHC 9/06/07

CONSENT TO EXAMINATIONS AND TREATMENT

Consent and authority is hereby given to this mental health facility and its professional staff to perform or have performed examinations and / or psychotherapy and / or related mental health treatments and to administer medications when deemed necessary or advisable by appropriate members of the professional staff in consultation with me. This statement has been fully explained to me and I understand it.

Witness _____ Signature of Patient _____

Date _____ Signature of Parent or Legal Guardian _____

I have been provided copies of the SCDMH Notice of Privacy Practices and Client Rights and an opportunity to ask questions:

Signature _____ Date _____ (If not signed, staff to state reason on line and initial)

SIGNIFICANT OTHER PARTICIPANTS INVOLVED IN THE IDENTIFIED PATIENT'S SERVICES

I agree to participate in therapy focused on the patient signing above. I understand that any information that I give may be included in the patient's record and disclosed as allowed by law. I also understand that if I want to receive therapy or other treatment services, a separate consent to examination and treatment is required.

Participant / Relationship	Date	Staff Initials

The staff who obtain the other participant signature above enter initials and signature here.

Staff Initials _____ Staff Signature _____ Staff Initials _____ Staff Signature _____

Berkeley Community Mental Health Center

Client Orientation Checklist

I have received the following information about the Center via a client handbook, separate brochure, and/or orally, and I have been given the opportunity to ask questions.

- Rights and Responsibilities
- Complaint and appeal procedures
- Ways to give input
- Services and activities; coordination with other agencies
- Expectations; importance of family involvement in treatment
- Hours of operation
- Access to after-hour and emergency services
- Code of Ethics and professional conduct
- Confidentiality Policy
- Requirements for reporting and follow-up if court-ordered to treatment
- Financial obligations, fees, and arrangements
- Familiarization with premises including emergency exits and/or shelters, fire extinguishers, and first aid kits
- Program's health and safety policies regarding:
    - use of seclusion/restraint
    - use of tobacco products
    - illegal and legal drugs
    - prescription medication brought into the program
    - weapons
    - drug screens
- Identification of your primary contact staff person
- Program rules and expectations, including:
    - restrictions
    - events, behaviors, or attitudes leading to loss of privileges
    - means by which rights or privileges that have been restricted can be regained
- Education regarding Advance Directives
- Purpose and process of the assessment and potential course of treatment
- Development of the Plan of Care and your participation including discharge/transition criteria and procedures
- Assistive technology that might be helpful in treatment

Client Signature _____ Date _____ CID# _____

Staff Signature _____ Date _____

SOUTH CAROLINA

VOTER REGISTRATION DECLINATION FORM

If you are not registered to vote where you live now, would you like to register to vote here today?

☐ YES ☐ NO

☐ Already registered to vote

☐ Will use registration by mail application.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application from in private.

If you decided to register to vote, that decision will remain confidential and be used only for voter registration purposes.

If you register to vote, information regarding the office in which the application was submitted will remain confidential, again, to be used only for voter registration purposes.

_____

Signature of Declinee/Applicant

_____

Date

If you believe that someone has interfered with your right to register or to decline to vote, your right to privacy in deciding whether to register or in applying to vote, you may file a complaint with the following:

Executive Director
State Election Commission
P.O. Box 5987
Columbia, S.C. 29250
(803) 734-9060

Berkeley Community Mental Health Center

CLIENTS WHO ARE COURT ORDERED TO TREATMENT

If you have been court ordered to treatment, this means that the Mental Health Center has a responsibility to work with the Court to ensure that you are in compliance with the order to treatment. We will need to contact the Court to let them know that you have entered treatment and that you are or are not following treatment recommendations. If you should cease your compliance with the order from the Court, we are required to contact the Court with this information. This may result in a supplementary hearing by the Court to decide the next course of action. The Mental Health Center desires a good working relationship with clients who are court ordered to treatment; however, clients should be aware of the requirements of their court order. If records or your counselor are subpoenaed to court information may be released by court order without your permission. All information requested by the judge must be released, but only the specific information requested is released.

I have read and understand the above information.

_____ _____

SIGNATURE DATE

_____

WITNESS

_____ _____

CLIENT NAME **CID**

Berkeley Community Mental Health Center

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? _____ YES _____NO

IF YES, WHOM? (SEE M-450D form)

If YES, complete and sign SCDMH Form M-450D "AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION" indicating your preferences. If applicable to a specific SCDMH inpatient facility, SCDMH/DIS Form M-450J Authorization (which expires upon discharge) may be used instead.

You may revoke or modify your Authorization in writing as further described in the Authorization.

This Notice and any resulting disclosure is subject to applicable law, including Section 44-66-75 (A), Code of Laws of South Carolina, as amended (requiring this Notice); 45 CFR Part 160 (HIPAA); 42 CFR Part 2 (alcohol and drug); 44-22-100, SC Code (SCDMH patient confidentiality); and SCDMH Privacy Practices, which may permit, but not require, such disclosure with applicable Authorization.

Print Patient Name: X_____

Patient Signature: X_____ Date: _____

AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, _____, at _____
(Name of requestor) Address (Street, City, State, Zip)

DOB _____, SS# _____, Medical Record # _____ authorize the release of my SCDMH health information, as specified below, for the following purpose: medical designee .

I authorize the release of the following information for the time period from: _____ to _____ .

☐ Information from **all** SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☐ Information from (name of specific hospital): _____

AND **The information authorized to be released includes:**

☐ All information from above
☐ Diagnoses
☐ Clinical History & Evaluation
☐ Admission and Discharge Dates
☐ Individualized Treatment Plan Progress Summaries
☐ Discharge Summary (Summary of Treatment)
☐ Physician's Medication Orders
☐ History and Physical
☐ Psychiatric History and Mental Status Examination
☐ Consultant Notes
☐ Billing and Payment Information
☐ Written Summary (copy attached)
☐ Other: _____

This information should be released to:

Name: _____

Address: _____

_____

Telephone No.: _____

Relationship: _____

I understand that the above information is protected by applicable law and if this form is not complete, SCDMH may not be able to release the information. I understand that the information may include alcohol/drug abuse and/or HIV/AIDS/ARC and other infectious disease information about me. I do not want the following information disclosed:

_____

This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here:

_____

I understand that information disclosed may be subject to re-disclosure by the entity named above. I may cancel this Authorization by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization, and SCDMH must keep records of my treatment. I understand that I may refuse to sign this Authorization and my refusal will not limit my access to SCDMH treatment or other services. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my Authorization. I have been given a copy of this Authorization.

Signature of Individual/Personal Representative	Printed Name	Date

Authority if signed by Personal Representative _____

Signature of DMH Staff releasing information	Printed Name	Method of Release	Date Released

Patient Identification

Berkeley Community Mental Health Center Therapy Expectations Contract
Adult Services Program

Patient: _____ CID# _____

At Berkeley Community Mental Health Center, we strive to provide the best treatment for all of our patients. We use the Adult Services Treatment Model and Level of Care System so that we can meet the unique needs of you, our patient, and design a treatment plan that helps you achieve your goals. As stated in the Adult Services Treatment Model brochure, we use both individual and group therapy modalities to help our patients achieve these goals.

I have received a copy of the Adult Services Treatment Model brochure and I have had the opportunity to ask questions about Berkeley Community Mental Health Center services and 3 phases of treatment (Individual Therapy, Group Therapy, and Reassess for Level of Care). I agree to participate in my Plan of Care and follow the recommendations of my treatment team, in order to meet my goals.

_____ _____

Patient signature Date

We know that our patients get the most out of therapy when they attend sessions consistently. We are also concerned about having appointment times available for patients who need and want to be seen. Therefore, we ask that you agree to the following statements:

Please initial next to each item:

_____ If I need to cancel an appointment, I will call my counselor at least 24 hours before my scheduled appointment.

_____ If I am ill, I will call my counselor as soon as possible to cancel my appointment. Twenty-four (24) hours of notice is requested to cancel an appointment whenever possible. (Note: Please do not come to the center if you are ill. We hope you will take care of yourself and prevent spreading contagious illness to our staff and other patients.)

_____ If I have difficulty remembering my appointments, I will speak with my counselor about a plan to ensure I attend all scheduled appointments.

Because my treatment goals cannot be accomplished unless treatment sessions are consistent, I understand that my case may be discharged if I do not adhere to these expectations and/or if I miss three (3) scheduled appointments in 90 days. My signature below indicates that I understand and agree to follow this therapy expectations contract.

_____ _____

Patient signature Date

_____ _____

Witness signature Date

DMH South Carolina Department of Mental Health

ELECTRONIC COMMUNICATION CONSENT FORM

As a patient or caregiver of a patient at South Carolina Department of Mental Health (SCDMH), you may wish to communicate with SCDMH staff by email. Your health is important to us and we will make every effort to reasonably comply with your request. We may deny requests for email communications if or when your clinician determines that it would not be in your best interest.

Our office will use reasonable means to protect the privacy of email information sent and received. However, we cannot guarantee the security of email communication. Patients must consent to the use of email for patient information, billing, and communication.

Below are policies outlining when and how email should be utilized to maintain your privacy and to enhance communication, as well as a place for you to acknowledge your consent to its use. Your decision to use email is voluntary and your consent may be withdrawn at any time.

When may I use email to communicate with SCDMH staff?
Email may be used for routine requests. Some examples are:

- Appointment scheduling
- Appointment reminders
- Routine questions
- Referral information
- Requests for medical excuses
- Telehealth links
- Other matters not requiring an immediate response

When should I NOT use email to communicate with SCDMH staff?
Email should never be used:

- In an emergency—use the 24 hour crisis line for emergencies (833-364-2274)
- If you are experiencing any desire to harm yourself or others
- If you are experiencing a severe medication reaction
- To communicate highly sensitive topics
- If you need an immediate response

What are the risks of using email?
Risks of communicating via email include but are not limited to:

- Email may be accidentally sent to an unintended recipient.
- Email may be intercepted by hackers and redistributed.
- Employers/online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email.
- Emails can introduce viruses, malware, or other malicious programs that may damage the computer.
- Email can be used as evidence in court.
- Emails can be intercepted, forwarded, circulated, stored or even changed without the knowledge or permission of either the sender or recipient.
- Copies of an email may continue to exist, even after the email is deleted.

Patient ID:

What happens to my messages?

- Emails will be maintained as a permanent part of your medical record.
- As part of your permanent record, they may be released along with the rest of the record upon your authorization or when it is otherwise legally required to do so.
- Messages may be seen by staff for the purpose of filing or carrying out requests (e.g., appointment scheduling).

What are my obligations?

- I must let SCDMH staff know immediately if my email address changes.
- If I do not receive a response within 24 hours, or the timeframe discussed by my clinician, I will contact him/her by telephone if a response is needed.
- I will use email communication only for the purposes stated above.
- I will advise my clinician in writing, should I decide that I would prefer not to continue communicating via email

What steps has SCDMH taken to protect the privacy of my email communications?

- SCDMH email encrypts email messages.
- Every SCDMH computer has a password protected screen-saver.
- SCDMH staff are educated on the appropriate use and protection of email.
- SCDMH staff will not forward patient email to third-parties without your express consent.

What steps can I take to protect my own privacy?

- Do not use your work computer to communicate with SCDMH, as your employer has a right to inspect emails sent through the company's system.
- Do not use a shared email account to transmit messages.
- Log out of your email account if you will be away from your computer.
- Carefully check the address before hitting "send" to ensure that you are sending your message to the intended receiver.
- Avoid writing or reading emails on a mobile device in a public place.
- Avoid accessing email on a public Wi-Fi hotspot.

Encryption Waiver

SCDMH staff will encrypt all emails sent outside of the SCDMH agency network to protect your privacy. If you are unable to accept encrypted communication for any reason, but still would like to accept emails from SCDMH, you may waive your right to encryption, with the understanding that your information will be less secure.

Please initial here if you prefer NOT to use encryption _____.

CONSENT TO EMAIL USE

By signing below, I consent to the use of email communication between myself and SCDMH. I recognize that there are risks to its use, and despite SCDMH's best efforts, confidentiality cannot be guaranteed. I understand and accept those risks and the policies for email use outlined in the form. I agree to follow these policies and agree that should I fail do so, SCDMH may cease to allow me to use email to communicate with SCDMH. I also understand that I may withdraw my consent to communicate via email at any time by notifying SCDMH staff in writing.

_____ _____

Name of Patient/Guardian Date

_____ _____

Signature of Patient/Guardian Email Address

Patient ID: