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 **Gender:** _____ **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:** _____

Third Party Guarantor of Payment Form

Patient Name: _____ DOB: _____

CID#: _____

Person Guaranteeing Payment for Services

If patient and guarantor are the same person, check here ☐ , if not

Relationship to patient: _____

First Name: _____ Middle: _____ Last: _____

Guarantor Social Security #: _____ Guarantor's DOB: _____

Address (if different from patient): Street: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____

Employed by: _____ Work Phone: _____

Insurance Information:

Insurance Company #1: _____

Customer Service #: _____

Subscriber Name: _____

Subscriber DOB: _____

ID#: _____

Group Number or Name: _____

Subscriber SSN: _____

Insurance Company #2: _____

Customer Service #: _____

Subscriber Name: _____

Subscriber DOB: _____

ID#: _____

Group Number or Name: _____

Subscriber SSN: _____

Insurance Company #3: _____

Customer Service #: _____

Subscriber Name: _____

Subscriber DOB: _____

ID#: _____

Group Number or Name: _____

Subscriber SSN: _____

Consent and Signature

For School Mental Health Services Only

☐ I understand that some insurers do not cover services provided in a school setting, and that I am responsible for full payment if my insurance does not cover SCDMH clinicians assigned to my student. I understand that I can still receive services in the local SCDMH clinic or another outside provider.

☐ I accept SCDMH services in the schools. I assume responsibility for payment, if school based services are not covered by my plan.

☐ I decline SCDMH school services. I understand that my student can still receive covered services in the local SCDMH clinic or another outside provider.

I understand that I am responsible for all payments on any balances owed for services performed on behalf of the client named above. This may include co-pays, deductibles, or services not covered by a third-party. Should the client be older than eighteen years of age, my payment for services does not entitle me to review any confidential treatment information without written consent of the patient.

Printed Name _____

Signature _____ Date _____

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:

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

Signature Date

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 _____

Berkeley Community Mental Health Center Therapy Expectations Contract
Children, Adolescents, and Families (CAF) Program

Patient: _____ CID# _____

At Berkeley Community Mental Health Center, we strive to provide the best treatment for all of our patients. We involve caregivers in all aspects of their child's treatment and design a treatment plan that helps you achieve your child's and your family's goals.

I have received a copy of the Children, Adolescents, and Families (CAF) Clinic Based Services brochure and have had the opportunity to ask questions about Berkeley Community Mental Health Center services and the "We Believe" information. I agree to participate in my child's Plan of Care and follow the recommendations of my child's treatment team, in order to meet our treatment goals.

_____ _____

Parent/Legal Guardian's 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 child's counselor at least 24 hours before my scheduled appointment.

_____ If I am ill or my child is ill, I will call my child's 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 or your child or children 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 child's appointments, I will speak with my child's counselor to create a plan to ensure my child and/or I attend all scheduled appointments.

Because treatment goals cannot be accomplished unless treatment sessions are consistent, I understand that my child's case may be discharged if I do not adhere to these expectations. My signature below indicates that I understand and agree to follow this therapy expectations contract.

_____ _____

Patient signature Date

_____ _____

Parent/Legal Guardian's 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: