The Healing Chamber, LLC

CoConsumer:	**Record #:**

Medicaid ID #: **Date of Birth:**

INTAKE PACKET
Client Information Sheet

Name: John Doe

Phone #:
Address:
DOB: 01/01/01
Sex: SS# _____ Race: OTHER
Medicaid #: A123456789
Who Does Consumer Live With? _____ Last Dr. Appointment: _
Weight ____ Height ____
Physician: _____ Phone #_____ Address: _____
Emergency Contact: _____ Relationship: _____Phone # _____
Address: Medications:

Name	Dose	Times	Name	Dose	Times

Diagnosis Date

☐	Anxiety	☐	Bi-Polar	☐	HIV, VD, Other	☐	Alcohol Abuse
☐	Depression	☐	MDD (major Depression)	☐	MR (mental retardation)	☐	Drug Abuse
☐	Down Syndrome	☐	ADD / ADHD	☐	Blind	☐	Bowel Problems
☐	schizophrenic	☐	Alzheimer's	☐	Hepatitis	☐	High Blood Pressure
☐	Diabetes	☐	Seizures	☐	Ambulation	☐	Stroke
☐	Glaucoma	☐	Prosthesis	☐	Cataracts	☐	Asthma
☐	Acid Reflux	☐	Arthritis	☐	Bladder Problem	☐	COPD
☐	Heart Attack / CHF	☐	Catheter	☐	PAD	☐	Other

Have you been hospitalized in the past 5 years? ____ No (if yes, explain) _____
Have you had any traumatic trauma in your life? ____ No (if yes, explain) _____.
What are you currently being seen by Dr. for? _____
Have you ever been incarcerated? ___ No (if yes, explain) _____ Are you currently having legal troubles? ___ No (if yes, explain) _____

OPT INTAKE THE HEALING CHAMBER Confidential

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Devices used:

☐	Glasses	☐	Walker	☐	Cane	☐	Hearing Aide
☐	Bed/Chair bound	☐	Hospital bed	☐	Wheelchair (man/elect)	☐	Bedside commode
☐	Shower Bench	☐	Bath Safety bars	☐	Detachable showerhead	☐	Elevated toilet seat
☐	Dentures	☐	Oxygen in use	☐	Location of pain:		Rate Pain 1-10:

Services Requested:

Name: _____ DOB: _____ ☐Outpatient

Therapy

X_____ _____
Consumer/Guardian Signature Date

CONSENT FORM

ACKNOWLEDGEMENT STATEMENTS

☐I have received the Client Confidentiality/Privacy Agreement handout which has been explained to me and I understand the contents to be released, the need for information and that there are statutes and regulations protecting the confidentiality of information.

☐I further acknowledge that I have received the HIPPA Notice of Privacy statement and understand information contained in the document and this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.

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☐I have received the Client Rights which explains my rights as a consumer, and I understand the contents.

☐I have received the Client Grievance Policy which explains my right to file a grievance and I understand the contents.

REQUIRED REPORTING

The Healing Chamber LLC is required by state and federal regulations to report non-identifying client information for the purpose of evaluation and funding purposes. It will also be necessary for The Healing Chamber LLC to use and disclose certain information about myself in order to carry out

treatment, payment and health care operations.

REPORTING OF SUSPECTED ABUSE/NEGLECT

The Healing Chamber LLC professionals are required by state laws to report suspected abuse or neglect to the appropriate authorities. If you have any questions about this, please feel free to ask for a better understanding before you sign this document. Your signature below acknowledges receipt of this information.

☐**PERMISSION FOR TRANSPORTING AND OFF-SITE ACTIVITIES**

During treatment, the client may require transporting to School and events, activities in the community, outings in and out of the State of Arizona. During these times, the client/parent/guardian agrees to release The Healing Chamber LLC from all liability and responsibility. The client gives permission The Healing Chamber staff to transport the client during program hours for treatment purposes by use of personal or agency vehicles. This consent is valid until separation from the program or by written termination of permission by client.

☐**EMERGENCY TREATMENT / EMERGENCY INFORMATION / EMERGENCY RESTRICTIVE INTERVENTION** In case of sudden illness/accident/emergency, I hereby give permission to the staff The Healing Chamber to seek emergency treatment on behalf of the below named client should the need arise. It is understood that this treatment will be provided by a qualified medical professional, physician, and/or hospital emergency room personnel. In addition, a copy of current medications and known medical conditions and allergies may be released. Efforts will be made to contact the identified emergency contact person prior to treatment, should this be possible. I also will hold harmless The Healing Chamber against any liability caused by their taking of any emergency procedures and/or contacts.

☐I agree to the emergency procedures as outlined above.

☐I will assume the full responsibility of all incurred emergency treatment expenses.

☐Emergency restrictive interventions will only be utilized when a consumer presents an imminent danger to him/herself or others or when substantial property damage is occurring. Whenever possible, less restrictive interventions will be used prior to the use of restrictive intervention.

CONSENT FOR SERVICES

☐I agree to participate in the treatment, services and support that are provided by The Healing Chamber as outlined in the client's service plan. I have been informed of the services in terms that I can understand. I have also been informed of the alleged benefits, potential risks, and possible alternative methods of treatment. I understand that I am free to discontinue services at any time.

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☐I agree to accept the following checked services from The Healing Chamber. Further, I knowledge that The Healing Chamber employee has not, in any way, advertently or inadvertently influenced my choice of services or providers.

☐Outpatient Therapy ☐Diagnostic/Clinical Assessment

The above consents have been read by me or to me and explained to me by an employee of The Healing Chamber in simple non-technical language, that all questions have been answered to my satisfaction and that I understand my rights.

X _____ _____

Consumer/Guardian Signature Date

X _____ _____ Witness Signature

Date

The Healing Chamber, LLC

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Acknowledgement of Receipt Form

Consumer Name: _____ Record: _____ Please

initial next to each line item below to indicate you have received these notices.

_____ I have received a copy of the **The Healing Chamber** Notice of Privacy Practices

_____ I have received copies of **The Healing Chamber** Client Rights and Grievance Policies.

X_____ **X**_____
Signature of Consumer / Legal Representative Printed Name

_____
Date

If the consumer is unable to sign for receipt of the Notice of Privacy Practices and Clients Rights and Grievance Policies, the individual who provided a copy of these notices should complete the form below:

Consumer was provided a copy of the **The Healing Chamber** Notice of Privacy Practices and copies of **The Healing Chamber** Clients Rights and Grievance Policies, but was unable to sign the acknowledgement forms due to:

X_____ **X**_____
Signature of Consumer / Legal Representative Printed Name

_____ Signature
of Clinician / THC Staff

_____
Printed Name

Demographic Form

Client's Name: Client's SS#
DOB: Age: Sex: Race:
If military, Sponsor's Name & S.S. #

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Home Phone_ Business or alternative phone

Please tell us how you were referred:
Complete this section only if less than 18 years of age:

Father's Name Mother's Name Father's work phone Mother's work phone Father's employer Mother's employer

Insurance Information (if applicable)

Insurance Carrier

Sponsor's or Insured's Name

Sponsor's S.S. # or Insured's ID # Group #

Authorization #

Secondary Insurance Carrier

Sponsor's or Insured's Name

Sponsor's S.S. # or Insured's ID # Group #

• With my signature, I allow **The Healing Chamber** (THC) to **file my insurance** and I assign benefits to them. I allow THC to release all necessary information from my records in order to file such claims. • My signature also indicates **my consent** for myself or my child to participate in treatment and/or evaluation. • It acknowledges that I have been informed about **HIPAA** (Health Information Portability and Accountability Act of 1996) which discusses how my personal health information may be used and/or disclosed, my rights with respect to health care information, and how and where I may file a privacy-related complaint. • It acknowledges that I have been provided with information regarding my **rights and responsibilities** as a patient at this practice.

• I also understand that I am responsible for ALL payments, co pays/deductibles as a self-pay and /or insured patient.

X_____ _____

Signature Date

AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF INFORMATION

CLIENT NAME: MR#:

MEDICAID ID#: DOB:

*I hereby request and authorize **The Healing Chamber** to release and exchange information to:*

Person/Agency Address Phone /Fax

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Primary Care Provider

_____

_____

(The following information will be released or exchanged (Check all that apply)

☐Psychological Evaluation	☐Treatment Plan and Diagnosis	☐Medication/Medical History
☐Psychiatric Evaluation	☐Alcohol/Drug treatment	☐Admissions/Clinical Assessment
☐Progress Note(s)	☐Insurance Information	☐Other (specify):
☐Discharge Summary	☐School related Information/IEP	☐Other (specify):

The purpose of this disclosure is for the coordination, linkage, and provision of services.

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by the laws.

I understand that I may revoke this authorization at any time unless this authorization is given as condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or claim under the policy. In any event, if not revoked earlier this authorization automatically expires one year (365 days) from signature date.

I understand that I may refuse to sign this authorization form. I understand that **The Healing Chamber** will begin and continue the treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely, voluntarily, and without coercion. I understand health insurance and information, indicated by initials, will be disclosed. Consumer:
Date:

Legally Responsible Person: **X**_____ Date:

Witness: _____ Date: ☐**I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement requesting revocation signed and dated by the above name person or guardian**.

Consumer/Guardian: _____ Date:

Witness: _____ Date: _____

Grievance Policy

We want to know if you are ever dissatisfied with services provided by **The Healing Chamber** This notice will tell you about what to do if you want to make a complaint to **The Healing Chamber** You have the right to file a complaint/grievance or

request voluntary mediation if available, and the right to have oral and written instructions and assistance in an accessible format for filing a complaint/grievance or medication; to report concerns or problems without fear of services being denied or reduced as a result of your complaint and without fear of mistreatment; To expect a response by Our Agency to all formal complaints.

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The Healing Chamber clinicians must refer clients, their representatives, or facility staff acting on the behalf of clients to the Director of Clinical Services or Compliance Officer in the event of grievances concerning The Healing Chamber or its employees. They will investigate the complaint by appropriate means, which might include contact with the client or representative, review of medical and financial records, contact with facility staff or administrator, on-site visit to the facility, employee interviews, or other means to determine whether the complaint is substantiated and appropriate means of correction. The client, representative, or facility acting on the behalf of the client will receive a response within 10 working days.

If the client, representative, or facility staff acting on behalf of the client is not satisfied with the resolution offered, the client or representative may request that the grievance be reviewed by the CEO of **The Healing Chamber** A response will be rendered within 10 working days.

If the client, representative, or facility staff acting on behalf of the client is not satisfied with the resolution offered, the client or representative may request that the grievance be reviewed by the CEO of **The Healing Chamber** A response will be rendered within 10 working days.

The Healing Chamber will provide, upon request, contact information for reporting grievances to the AZ Medical Board, AZ Psychology Board, AZ Board of Social Workers, and AZ Board of Nursing, or Local Management Entity.

Complaint Contacts: _480-853-5514 **Signature X_____ Date _____**

FREEDOM OF CHOICE

I have been informed of the Outpatient Therapy services available to me/ client. I understand that I have the right to

choose the provider of Outpatient Therapy services, and I have been given the opportunity to choose between other enrolled Medicaid providers in my community setting.
As long as I remain eligible for OPT services, I will continue to have the opportunity to choose between qualified OPT providers.

I understand that I have the right to refuse OPT services. Refusal of OPT services does not prevent me from receiving other Medicaid services for which I may qualify.

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☐ I agree to receive Outpatient Therapy services for:

_____ _____
Beneficiary Name Medicaid Number

I choose The Healing Chamber as my provider for Outpatient Therapy services.

☐ I decline Outpatient Therapy services for:

_____ _____ Beneficiary Name
Medicaid Number

_____ _____
Signature of recipient Date signed (month, day, year)

_____ _____
Signature of: (check one) Date signed (month, day, year)

☐Guardian ☐ Family ☐Witness

_____ _____
_____ _____ Signature of
Therapist Date signed (month, day, year)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please review this document carefully and ask for clarification if you do not understand any portion of it.

The Healing Chamber must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of The Healing Chamber to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care and for other services relating to your health care.

I understand that as part of the provision of healthcare services, The Healing Chamber may create and maintain health records and other information. distributing among other things, my health history, progress toward goals, evaluation and assessment results,

crisis events, services or treatment, and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosure of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand and acknowledge that if I participate or am involved in a group process then the information shared is not private and secure. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

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The purpose of this Notice of Privacy Practice is to inform you about how your health information may be used within The Healing Chamber as well as reasons why your health information could be sent to other service providers outside of this agency.

This Notice describes your rights in regard to the protection of your health information and how you may exercise those rights. This Notice also gives you the names of contacts should you have questions or comments about the policies and procedures The Healing Chamber uses to protect the privacy of your health information.

_____ _____

Client Signature Date

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information which is used or disclosed for the purposes of treatment, payment or health care operations is restricted. I also understand that The Healing Chamber and I must: • agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and • agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

I have received The Healing Chamber Notice of Privacy Practices, which describes this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.

Client/Legal Guardian

The Healing Chamber Representative

Witness Signature Date