Navigate Remote / ORNC
Tracking & Contact Form

Consumer Name: Last _____ MI __ First _____
Navigate ID#: _ _ _ _ _

Referral Source: _____

Contact Information:
Primary Mailing Address: _____
_____
Secondary Mailing Address: _____
_____

Home Phone #: (_____) _____ Best times to call: _____ am/pm Leave Message: Y / N
Cell Phone #: (_____) _____ Best times to call: _____ am/pm Leave Message: Y / N
Work phone #: (_____) _____ Best times to call: _____ am/pm Leave Message: Y / N

Demographics
Gender _____ male _____ female ***Your Date of Birth*** _ _/_ _/_ _ _ _ ***Your present age in years*** _____

Self-Description (mark one)
_____ White American/European American
_____ African American
_____ Asian American/Pacific Islander
_____ Hispanic
_____ Native American
_____ Other (please specify) _____

What is the highest level of school you completed?
_____ Elementary School
_____ Middle School
_____ High School
_____ GED
_____ Associate's Degree
_____ Bachelor's Degree
_____ Graduate Degree
_____ Other: _____

What is your current Marital Status?
_____ Single
_____ Divorced
_____ Married
_____ Widowed
_____ Long-term Relationship/Partnered

Other Contact Numbers:

List people who might know how to reach the client if they should move (parents, siblings, other relatives, friends, co-workers, etc.)

(A). Name: _____ Relationship To Participant:_____
First Last Initial
Phone: (_____) _____ Best times to call: _____ am/pm

(B). Name: _____ Relationship To Participant:_____
First Last Initial
Phone: (_____) _____ Best times to call: _____ am/pm

(C). Name: _____ Relationship To Participant:_____
First Last Initial
Phone: (_____) _____ Best times to call: _____ am/pm

Key Dates:

Date of GAIN: _____

Version 0612

Navigate Counseling Clinic
4410 Health Sciences Building
ECU Mail Stop 677
Greenville, NC 27858-4353
(252) 744-0328
Fax (252)744-6311
navigate@ecu.edu

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Client Name: _____
Record Number: _____

I understand that as a client receiving services from Navigate I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that all information shared with the clinicians at Navigate is confidential and no information will be released without my consent. During the course of treatment at Navigate, it may be necessary for my therapist to communicate with others providers involved in my treatment. Under these circumstances, consent to release information is given through written authorization. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.

When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provides Navigate services. All professionals-in-training are supervised by licensed staff. I understand that while counseling may provide significant benefits, it may also pose risks. Counseling may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

If I have any questions regarding this consent form or about the services offered at Navigate, I may discuss them with my clinicians.

I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Navigate.

I consent to receive, if deemed necessary in emergency situations, "First Aid/CPR" from Navigate staff trained in these interventions. I also consent to receive emergency care from a hospital or physician.

I understand that I may stop treatment at any time.

_____ _____
Signature Date

Navigate Counseling Clinic

Consent for digital video or audio recording

I, _____ hereby authorize Navigate counselors to
(Print Client's Name)

record by ___ audio ___ video, our counseling sessions for supervisory purposes. I understand that these recordings may be viewed by my counselor's supervisor and my counselor's professional colleagues in small group (i.e. less than 10 people) or individual supervision for educational and consulting purposes for up to 6 months after the date this form is signed, after which the recording will be deleted.

I understand that I may revoke this consent* at any time except to the extent that action based on this consent has been taken, or if this form has been used to obtain insurance coverage for services provided. This authorization is fully understood and is made voluntarily on my part.

_____ Date _____
(Signature of Client or Legally Responsible Person)

_____
(Witness)

***In order to revoke consent, please contact:**
Navigate Counseling Clinic ~ 4425 Health Sciences Dr. ~ Greenville, NC 27834
Phone: (252) 744-0328 ~ Fax: (252) 744-6311

NAVIGATE Counseling Clinic
East Carolina University
Department of Addictions & Rehabilitation Studies
4410 Health Sciences Bldg – 4th Floor
Mail Stop 677
Greenville, NC 27858
(252)-744-0328
Navigate@ecu.edu

INFORMED CONSENT FOR NON-ROUTINE ASSESSMENT (BREATHALYZER)

Client Name: _____

Record Number: _____

In the event Navigate staff notice signs and symptoms of intoxication, I consent to complete a breathalyzer screening. I understand the results of this test will be reviewed by the Navigate Management Team and stored in my record. I further understand that the results of my test will determine services that may be needed as well as safety considerations including my ability to drive from Navigate. I also understand that by signing this consent, I do not forfeit my rights as a client.

If I have any questions regarding this consent form or about the services offered at Navigate, I may discuss them with my clinicians.

_____ _____
Signature Date

Client Handbook

Version 03/14

Table of Contents

Welcome to Operation Reentry

North Carolina!

Our mission is strengthen the resiliency and facilitate the reintegration of veterans through creative and innovative uses of technology.

Core Values:

1. Person Centered & Strengths-Based Orientation
   1.1. Therapeutic Relationship
   1.2. Client Self-Determination
   1.3. Individualized Services
2. Inclusive and Accessible
   2.1. Open to all regardless of…
   2.2. Culturally Sensitive and Competent Services
3. Service-Learning
   3.1. Integration of Knowledge and Practice for Helping Professionals-in-Training
   3.2. Developing Leadership in Professional Practice
4. Continuous Quality Improvement
   4.1. Training and Supervision of Team
   4.2. Using evidence-based practices to generate practice-based evidence

Your rights and responsibilities

ORNC: R&R is devoted to providing high quality, Client based services. It is equally important that you engage, to a level of personal comfort, in the services received.

Your confidentiality

Your confidentiality will be maintained within the guidelines set forth by the ECU Institutional Review Board, as well as the ethical code of the Commission on the Certification of Rehabilitation Counselors, the NC Board for Professional Counselors, the NC Substance Abuse Professional Practice Board, and the American Association for Marriage and Family Therapy.

Issues of duty to warn and protect will handled according to NC law.

Your rights

You have the right to:

- Be treated fairly, with respect and without prejudice or judgment;
- Participate in a safe environment;
- Privacy of personal information;
- Be informed of services available;
- Decide what services are appropriate;
- Agree to or refuse services at any time;
- End participation in ORNC: R&R at any time;
- Review information in your file; and
- File a complaint about the services received from ORNC: R&R, which is covered under "Grievance" on page 6.

Your responsibilities

You are expected to:

- Be willing to participate in the development of your service plan;
- Provide necessary information needed for project participation;
- Complete assigned activities that are part of your service plan;
- Not discuss information about other Clients in ORNC: R&R;
- Arrive to appointments sober and unimpaired; and
- Keep appointments or give notice as early as possible if unable to attend.

ORNC: R&R service van rules

The relationship among people who use the service van is important. Appropriate behavior is expected at all times.

The following behaviors are not acceptable:

- Discussing other Clients' information within or outside of the van;
- Yelling, swearing, or other disruptive behavior;
- Verbal or physical aggression or harassment;
- Possession of a firearm or any item usable as a weapon;

- Theft or damage of ORNC: R&R equipment;
- Trading, bartering, distribution, use and/or sale of illicit drugs or alcohol around van and/or service area;
- Trading, bartering, distribution, use and/or sale of prescription drugs around van and/or service area; and,
- Arriving to the service area/van intoxicated.

Disability accommodation requests

The client will make accommodation requests to the project coordinator who will make a decision with consultation from the ORNC: R&R Director(s) regarding appropriateness and reasonableness.

An attempt will be made to accommodate all reasonable requests.

Client feedback

Each Client will have the opportunity to provide feedback to project staff through a variety of methods. These include and are not limited to:

- Individual interviews at the time of entry regarding goals and expectations and at the exit interview to determine satisfaction with services and if goals were met;
- Through focus groups to solicit feedback on specific topics of concern to either the stakeholders or project staff; and
- An open door policy of all project staff is maintained to solicit and receive feedback, which is presented immediately to project directors and at weekly staff meetings.

Separation from services

Clients that continually violate the rules of the service area/van may lose the privilege to attend sessions or continue participation in the project.

ORNC: R&R takes the safety of all people within the service area and van very serious.

Any threat or action endangering those within the service area and van will result in immediate separation from services and project participation.

The police will be called for any violation of the law.

ORNC: R&R code of ethics

All ORNC: R&R team members are expected to behave in accordance with the codes of ethics proffered by the Commission on the Certification of Rehabilitation Counselors, the NC Board for Professional Counselors, and the NC Substance Abuse Professionals Practice Board and the American Association of Marriage and Family Therapy.

A copy of these documents can be provided to you upon request.

Grievance

If you have concerns/complaints, you are encouraged to take the following actions:

Step 1. Discuss the concern with an ORNC: R&R team member;
Step 2. If unsatisfied, Clients may speak directly and privately with an ORNC: R&R Coordinator;
Step 3. If unsatisfied, Clients may speak directly with an ORNC: R&R Director.
Step 4. If unsatisfied, Clients may call the Complaint Unit at the NC Division of Health Service Regulation 800-624-3004.

Services

- Assessment & Treatment Planning
    - Referral
- Treatments
    - Individual, Group, and Family Counseling
- Specialized Services
    - Personal Growth & Development
    - Career/Employment Counseling
    - Addictions & Clinical Counseling
    - Complimentary & Alternative Interventions
        - Art Therapy
        - Mind-Body
        - Biofeedback
    - Rehabilitation Counseling
        - Disability & Barriers to Quality of Life

Hours of operation

ORNC: R&R is mobile unit that provides services on a rotating basis. You will be provided with a schedule of when ORNC: R&R will be in your area. This may be in the form of an email, text message, ACHESS notification, Facebook post, and/or a Tweet depending on your use of technology and/or social media platforms used.

If you are scheduled for an appointment, you will receive a reminder phone call, text, and/or email, if you authorize us to contact you.

ORNC: R&R contact information

The primary point of contact for Clients is **252-375-0188**.

The afterhours ***crisis*** line for Clients is **252-378-8498**.

Service – Waiting Area

The ORNC: R&R waiting area will be near the service van. If you are waiting for your appointment, please remember not to discuss your private matters and/or other clients' private matters, as it is important that they remain confidential.

Please remember that we do not allow weapons of any type in the service area and/or on the service van. Upon arrival, an ORNC: R&R staff member will ask if you have any weapons on your person and ask you to sign-in affirming that you have no weapons.

If you have any weapons in your belongings or on your person at the time you arrive to the service area, your appointment will be rescheduled.

ORNC: R&R

Receipt of Client Handbook

I, the undersigned Client, have received, reviewed, and inquired about any questions and/or concerns that I have with an ORNC: R&R staff member.

I, the undersigned Client agree to the policies of ORNC: R&R, as written in this Client handbook.

I, the undersigned Client, agree to abide by the Weapons Policy for ORNC: R&R.

Signed_____ Date_____
Signature of Client

Witness_____ Date_____
Signature of Staff Member

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AUTHORIZATION for RELEASE of INFORMATION

Client's Name_____ Date of Birth_____/____/____
Last First M.I. Mo. Day Year

I, _____, hereby authorize the Navigate Counseling Clinic to **release/obtain** information pertaining to attendance, progress, goals, and other information listed below **to/from**:

_____

for the purpose of:_____
(indicate the specific reason)

_____

Additional Information (Consumer should initial next to each item):

1. _____ Consumer Initial _____
2. _____ Consumer Initial _____
3. _____ Consumer Initial _____

I understand that authorization shall remain valid from the date of my signature below and for 12 months thereafter ending on:_____

I have been informed that I may revoke this authorization by written or oral communication to Navigate. I certify that this form has been fully explained to me and that I understand its contents.

_____ _____
Signature of Consumer Date of Authorization

_____ _____
Signature of Witness Date

East Carolina University
Health Care Components
Notice to Patients About Our Privacy Practices

1. The purpose of the attached Notice of Privacy Practices (Notice) is to tell you how we can use and disclose your health information. It also describes certain rights that you have about your health information kept by us. Please look at it with care.

2. We are legally required to give you this Notice and to get a signed statement that you received it. By signing this, you are only saying that you have received our Notice.

3. This Notice also has persons you can contact if you have any questions. It tells you how to file a complaint if you think your rights have been denied. It also tells you how to file a complaint about our practices described in the Notice.

By signing this paper, you confirm receipt of East Carolina University's Health Care Components Notice of Privacy Practices.

_____ _____

Patient Signature **Date**

_____ _____

Parent/Guardian Relationship to Patient **Date**

Completed by Component Staff Providing Notice:

_____ _____ _____

Print Patient Name Date of Birth Medical Record Number

_____ _____ _____

Signature & Name of Staff Providing Notice Date Location/Clinic

Disposition
Remove Original with Signature and file in Component's Designated Record Set/Medical Record. Provide Patient with Remaining Packet.

East Carolina University
Health Care Components
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE: April 14, 2003

As a Health Care Component of East Carolina University, the law requires us to protect the privacy of your health information. We call this your "protected health information (PHI)". We are also required to tell you of our duties to protect your PHI and to explain our privacy guidelines.
We are required to follow the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice. These new guidelines will be valid for your entire PHI that we keep. Copies of our Notice are on hand at all of our Health Care Components. You can also contact the Privacy Official. That address and phone number are at the end of this Notice. You can see the Notice at any of our sites and on our website at http://www.ecu.edu/ecuphysicians.

We are required to include in this Notice certain descriptions that reflect a higher level of protection before we use or disclose your PHI as described below. There are many laws that may offer this additional protection of your PHI. Our Health Care Components have procedures in place to consider this protection before using or disclosing PHI. You may contact the Privacy Official if you believe this may apply to your PHI.

1. WE MAY USE AND REVEAL PHI ABOUT YOU WITHOUT YOUR AUTHORIZATION IN THE FOLLOWING SETTINGS.

 Treatment: We may use and reveal PHI about you to provide or coordinate health care treatment provided to you.

EXAMPLE - Your doctor may share PHI about you with another health care provider, or by ordering lab or radiology services, or by calling in a prescription.

 Payment: We may use and reveal PHI about you to obtain payment for services. This could include certain sharing of PHI that your health insurance plan may require before it approves or pays for the health care services we advise for you.

EXAMPLE – Your health plan may have to approve any treatment. We will have to share your PHI with them so they will approve the treatment. We may also have to share more of your PHI with them after treatment so they will pay us.

 Healthcare Operations: We may use or reveal PHI about you to carry out certain business actions separately or as part of our involvement in an Organized Health Care Arrangement (OHCA) with Pitt County Memorial Hospital. These actions include, but are not limited to, quality assessment activities, training of medical students and residents, licensing, solving complaints, and carrying out other business actions.

EXAMPLE – We are reviewed by outside groups that measure the quality of the care our patients receive. They include government agencies or accrediting groups. We also review and measure the skills and training of the doctors that care for you. Both ECU and non-ECU health care workers not directly involved in your care may do such reviews.

2. WE MAY USE AND REVEAL PHI ABOUT YOU IN A NUMBER OF OTHER SETTINGS IN WHICH YOU DO NOT HAVE THE CHANCE TO AGREE OR OBJECT. THESE MAY INCLUDE:

 Required By Law: For certain legal or other administrative actions. For example, we may reveal PHI about you in response to a court order.

 Public Health: For public health activities required by law to receive the information.

 Health Oversight: To health oversight agencies for legally allowed audits, investigations, certain government programs, and inspections.

 Abuse or Neglect: To a public health expert for reports of child abuse or neglect. We may reveal PHI if we believe that you have been a victim of abuse, neglect or domestic violence to governmental agencies who are allowed to receive such information.

 Food and Drug Administration: To a person required by the Food and Drug Administration to report harmful events, product defects or problems, tracking of products to permit recalls, or to conduct post marketing surveillance.

 Law Enforcement: Law enforcement reasons may include (1) legal courses of action required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the site of the practice, and (6) medical emergency when it is likely that a crime has occurred.

 Coroners, Funeral Directors, and Organ Donation: To a coroner or medical examiner for identification purposes, or to find out the cause of death. We may also reveal protected health information to a funeral director in order to permit them to carry out their duties. PHI may be used and revealed if you are an organ, eye, or tissue donor.

 Research: PHI may be used for research without the individual's authorization if the University and Medical Center Institutional Review Board (UMCIRB) grants a wavier of the requirement for authorization. Two scenarios that require neither authorization nor waiver of authorization: 1) reviews preparatory to research, and 2) research on decedent's information.

 Criminal Activity: We may use or disclose PHI as necessary to prevent or lessen a serious threat to the health or safety of a person.

 Specialized Government Functions: We may use or disclose PHI for the purpose of eligibility determination by the Department of Veterans Affairs. We may also reveal your PHI with federal officials for conducting national security activities and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.

 Inmates: If you are a prisoner and your doctor created or received your PHI in the course of giving care to you.

 Worker's Compensation: We may use or disclose PHI as necessary to support worker's compensation claims pending before the Industrial Commission.

3. OTHER USES AND DISCLOSURES OF PHI ABOUT YOU.

 Appointment Reminders: We may contact you to remind you of an appointment for treatment.

 Information About Treatment, Services or Products: We may use or reveal PHI to manage your care. This may include telling you about treatments, services, or products on hand.

 Fundraising Activities: We may use or reveal PHI about you in order to contact you to raise money for ECU and its Health Care Components. We would only reveal contact information and the dates you received treatment or services from us. If you do not want us to contact you about fundraising activities, you must tell our Privacy Official as described below.

 Family or Personal Representative: In certain situations, we may use or reveal PHI to a family member, other relative, or a close personal friend of the patient, or any other person identified by the patient, PHI directly relevant to such person's involvement with the patient's care or payment related to the patient's care.

4. ANY OTHER USE OR REVEALING OF PHI ABOUT YOU CALLS FOR YOUR WRITTEN AUTHORIZATION.

 For any reason other than those listed above, we will ask for your written authorization before we use or reveal your PHI. Any written authorization we receive can be canceled at anytime in writing. We will not reveal PHI about you if you cancel your authorization unless we did this prior to your cancellation.

5. YOUR RIGHTS REGARDING PHI ABOUT YOU.

 Request Limits: You may request further limits on our uses and revealing of PHI about you. We are not required to agree to all requested limits. If we agree, there still may be circumstances such as those described above in which you cannot object. Ask the clinic front desk or contact the Privacy Official as described below if you want to request further limits on your PHI.

 Different ways to Contact You: You may request different ways for us to contact you about your PHI. Examples include using a different address, phone number, or mailing address. We will honor your request if we can. This will depend on whether or not we can contact you about how payment will be

handled. Ask the clinic front desk or contact the Privacy Official as described below if you want to change the way we contact you about your PHI.

 Right to see and get Copies of PHI: You may see and receive a copy of your PHI kept in our clinical or billing records used to make decisions about you. We may charge you for copies. There are times in which we do not have to fulfill your request. We will write to you in these cases. Ask the clinic front desk or contact the Privacy Official as described below if want you want to see or get copies of your PHI.

 Right to Request Amendments of PHI: You may request that the PHI that we keep about you be changed. We may turn down your request if we did not create the information, or if we believe the information is correct. If we turn down a request, we will write to you and will describe your rights for further review. If we agree to change, we will make every effort to share with any persons who may have received PHI about you that needs changing. Ask the clinic front desk or contact the Privacy Official as described below if you want to request an amendment.

 Listing of Disclosures we have made: You may request a list of the persons or places that PHI about you was revealed to for up to the last six (6) years. This does not include information revealed before April 14, 2003 or those related to your treatment, payment, our health care operations, and those allowed

by law. Ask the clinic front desk or contact the Privacy Official as described below if you want to request a listing of disclosures.
 Copy of this Notice: You may request a copy of this Notice at any time. This will be on hand in our delivery sites, or you may contact the Privacy Official as described below.

6. YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES.
 If you think we have denied your privacy rights described in this Notice, or you want to complain to us about our privacy practices, you can contact the person below:

Privacy Official
Brody School of Medicine at East Carolina University
600 Moye Blvd., Suite 2W-31
Greenville, NC 27834
Phone 252-744-5200 or Email HealthCarePrivacy@mail.ecu.edu

You may also send a written complaint to the Secretary, Department of Health and Human Services. IF YOU FILE A COMPLAINT, WE WILL NOT TAKE ANY ACTION AGAINST YOU OR CHANGE OUR TREATMENT OF YOU IN ANY WAY.