Outreach Management Services, LLC
Face Sheet

Have you ever been a patient here: (please circle) YES or NO **Admit Date**:_____

Client Name: _____
Last First Middle AKA Maiden

SSN:_____ **DOB**:_____ **Primary Language**:_____ **Sex Assigned at Birth**:_____

Address:_____ **City**:_____

State:_____ **Zip Code**:_____ **County**:_____ **Home Phone**:_____

Cell Phone:_____ **Work Phone**:_____ **Email**:_____

Preferred method of appointment reminders: (circle one) text or phone call or email

Legal Guardian's Name: _____ **Phone**:_____

Gender Identity: (circle one)
Identifies as Female - Identifies as Male - Female-to-Male Transgender- Male-to-Female Transgender - Agender - Nonbinary - Gender Neutral - Gender Queer - Gender Expansive - Gender Nonconforming - Other - Don't Know - Decline to answer

Sexual Orientation: (circle one)
Straight or Heterosexual - Lesbian, Gay or Homosexual - Bisexual - Pansexual - Other - Don't know - Decline to answer

Preferred Pronouns: (circle one)
He, Him, His - She, Her, Hers - They, Their, Them - No preference - Other

Race: (circle one) Asian - Pacific Islander - African American - Native American - Caucasian - Other

Ethnicity: (circle one) Latino - Not Latino - Unknown

Marital Status: (circle one) Single - Married - Separated - Divorced - Widowed - Unknown

Living Arrangement: (circle one) Homeless - Private, Permanent - Facility - Residential - Other

Number of people living in household: _____
Names, Relationship, Age:

1._____ 5. _____
2._____ 6._____
3._____ 7. _____
4._____ 8. _____

Primary Physician:_____ **Location**:_____ **Phone**:_____

Psychiatrist: _____ **Location**:_____ **Phone**:_____

Currently Enrolled in any Psychiatric program? Y or N **If yes, what level**:_____ **Where**:_____

Ever been in the military? Yes or No **If child, what school do they attend?**: _____

Employment Status: (circle one) Unemployed - Full Time - Part Time - Student - Retired - Homemaker - Not Available - Armed Forces - Seasonal, Migrant - Other

Do you have psychiatric advanced directives? Y or N If no, are interested in receiving information? Y or N

If employed and uninsured or a Medicaid/IPRS recipient, what is your annual income?:_____

Next Appt:_____ **Client #**:_____

Outreach Management Services, LLC
Face Sheet

Client Name:_____ **DOB:**_____

Pharmacy:_____

Location:_____

Phone #:_____

Do you have insurance: (circle one) YES OR NO

Primary Insurance: _____ **Member ID**:_____ **Group #**:_____

Secondary Insurance: _____**Member ID**:_____ **Group #**:_____

Tertiary Insurance: _____ **Member ID**:_____**Group #**:_____

Income Attestation / Client Hardship Application for Partners Behavioral Health

Uninsured Patients ONLY

No Income Statement

I _____, do attest that I have no income currently. I also attest that I have no employment and receive no disability, SSI, or government funding. This information is given in good faith and should information be made available that shows otherwise, I understand that I am responsible for any and all fees that are applicable based on any discovered income. I also understand that my financial status should be re-evaluated every **180 days to assess any change in status.

_____ _____

Signature of Consumer/Guardian Date *Signature of Provider Agency Staff Witness Date*

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Client Name and DOB: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Mood Disorder Questionnaire (MDQ)

Name: _____ **DOB:**_____ **Date:** _____

Instructions: Check (✓) the answer that best applies to you. Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family in trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	○	○
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ○ No problem ○ Minor problem ○ Moderate problem ○ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Life Event Checklist Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Client Name:_____ **DOB:**_____ **Date:**_____

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden violent death (for example, homicide, suicide)					
15. Sudden accidental death					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Social Determinants of Health Assessment

Client Name:_____ Date of Birth:_____ Date:_____

There are local programs to help you with needs that can affect your health.
Are there things you need help with?

	Yes	No
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
1.a. Is having enough food a current need or concern?*	☐	☐
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	☐	☐
2.a. Is food not lasting a current need or concern?	☐	☐
3. Do you have housing?*	☐	☐
4. Are you worried about losing your housing?	☐	☐
5. Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?	☐	☐
5.a. Are having utilities a current need or concern?	☐	☐
6. Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?	☐	☐
6.a. Is this a current need or concern?	☐	☐
7. Do you feel physically and emotionally safe where you currently live?	☐	☐
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	☐	☐
8.a. Is this a current concern?*	☐	☐
9. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	☐	☐
9.a. Is this a current need or concern?	☐	☐
10. In the past 12 months, have you had trouble affording health insurance (such as deductibles, co-payments, etc.)	☐	☐
10.a. Is health insurance a current need or concern?	☐	☐
11. In the past 12 months, have you had trouble paying for or accessing medications?	☐	☐
11.a. Is this a current need or concern?	☐	☐
12. In the past 12 months, have you had concerns over obtaining or maintaining employment?	☐	☐
12.a. Is employment a current need or concern?	☐	☐

CRITICAL: For completion by therapist/staff: ☐ Check and initial _____, confirming that if three (in bold) or more of items 1.a, 2.a, 3 (if no), 5.a, 6.a, 7 (if no), 8.a, 9.a, 10.a, 11.a, 12.a. are checked that a plan will be developed to address the deficits.

*Essential; needs to be addressed immediately.

OUTREACH MANAGEMENT SERVICES, LLC

Client Name:_____ MCD/Ins. #:_____ Client#:_____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact:_____

Relationship to Client:_____

Telephone #: :_____ Cell Phone: _____

Address: _____

Name of preferred physician or hospital: _____

Address: _____

Telephone #:_____

AUTHORIZATION FOR EMERGENCY MEDICAL/DENTAL TREATMENT

In case of sudden illness/accident/emergency, I hereby give permission to the staff of Outreach Management Services, LLC. 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 Outreach Management Services, LLC. against any liability caused by their taking of any emergency procedures and/or contacts.

_____ _____

Signature of Parent/Guardian/Client Admit Date

_____ _____

Signature of Staff Admit Date

Client Name:_____ DOB:_____MCD/Ins:_____Client#: _____

Communicable Disease Screening

Are you currently having any of these symptoms or have you been in contact with anyone within the last 7 to 14 days that have had these symptoms?

- ☐ Nausea and vomiting.
- ☐ Diarrhea (may be bloody)
- ☐ Red eyes.
- ☐ Raised rash.
- ☐ Chest pain and cough.
- ☐ Stomach pain.
- ☐ Severe weight loss.
- ☐ Bleeding, usually from the eyes, and bruising (people near death may bleed from other orifices, such as ears, nose and rectum)

_____

Signature Admit Date

Client Name:_____ DOB:_____MCD/Ins:_____Client#: _____

Appointment Cancellation/No-Show Policy

We understand that unplanned issues can happen and you may need to cancel an appointment. If that happens, we ask that you cancel your appointment 24 hours in advance. Our physicians and therapist want to be available for the needs of our clients. **When a client does not show up for their scheduled appointment, another client loses the opportunity to be seen.**

The first time a patient no-shows their appointment they will be reminded of the no-show policy with a letter at their next visit, The second time a patient is a no-show they will be charged a $50.00 fee, as set by OMS, for missing two appointments. A patient who consistently fails to present themselves more than three times may be discharged from OMS.

Thank you for being a valued client and for your understanding as we enforce this policy. This policy will enable us to have more appointments available to better serve our clients.

_____ _____

Client Signature Date

OUTREACH MANAGEMENTSERVICES, LLC

Client Name:_____ DOB:_____MCD/Ins:_____Client#: _____

FINANCIAL AGREEMENT

I understand the following is my agreement with OMS:

☐ INSURANCE COVERAGE

☐**Insurance or other medical coverage.** I have medical insurance coverage, I will need to bring in necessary insurance information. OMS will file with certain insurance companies for certain services. I will make regular payments according to my payment plan below while my insurance is being processed and as needed after my insurance has paid OMS. I understand that I will be responsible for payment of deductibles, co-payments, non-covered services and/or balance amounts.

☐**I have NC Medicaid and/ or NC Health Choice coverage.** I will need to provide OMS with my current Medicaid and/or Health Choice eligibility card and the monthly updated eligibility cards so my claim can be filed.

☐**Assignment or Benefits,** I hereby authorize payment directly to OMS of benefits otherwise payable to me (insurance and other third party reimbursement).

☐**Release of Information,** I hereby authorize OMS to release specified information in my client record to my insurance company. This data shall include any information necessary to file any insurance claim and/or third party reimbursement. The specific purpose of this information is to collect fees for services rendered to me. This consent shall be valid for l (one) year. The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information. I understand the Federal 42 CFR and HIPAA guidelines protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ _____ _____ _____

Client/Legal Representative Signature Admit Date Staff/ Witness Signature Admit Date

☐ REDUCED PAYMENT I understand inability to pay must be proven and negotiated on an individual basis. My fees have been reduced based on my income level. I will be responsible for a percent of the fees.

I am approved at_____% of total fees. The total amount is $_____

☐ PAYMENT PLAN

My fees have been set up on a payment plan. I will make payments until my account is paid in full.

___Weekly ____Two Weeks ____Monthly ____Other Amount$_____

Date payments to begin: _____

☐ I will receive a monthly statement of charges and payments.

I agree to be the responsible party for payment of all fees for_____ I understand being responsible is part of the program.

_____ _____

Client/ Parent/ Guardian Signature Staff Signature

_____

Admit Date

NC HealthConnex
Powering Health Care Outcomes

North Carolina Health Information Exchange Authority
Patient Opt-Out Information

Updated 10/2/2019

The North Carolina Health Information Exchange Authority (NC HIEA) is operating North Carolina's Health Information Exchange, now called NC HealthConnex. NC HealthConnex is a secure, electronic network that allows participating medical providers to share your health information with one another. This enables participating physicians, hospitals, laboratories, pharmacies, and other health care providers to have access to important medical information about you that can assist them in making critical medical decisions for you.

Your Patient Record

Your patient record in NC HealthConnex will include information about your medications, allergies, laboratory results, and other information gathered during your encounters from your health care provider. Your record will also include your demographic data to help identify you when you visit different health care providers across the state. It will not include any information about you that federal law prohibits sharing without your express authorization, like psychotherapy notes and substance abuse treatment records.

Benefits of NC HealthConnex

What does it mean to be a part of NC HealthConnex network? As a patient, it means having peace of mind in visiting a new health care provider's office if they are participating in the NC HealthConnex. If your information has been uploaded before, your new provider will be able to access that data. This means they can spend less time taking down your history and spend more time treating you.

Participating in the NC HealthConnex is even more important if you visit an emergency department at a participating hospital and you are unable to provide critical information about your current health status to hospital staff, including your diagnoses, medications, and allergies.

Who Can See My Record?

Only participating health care providers and other HIPAA covered entities that have signed contracts with the NC HIEA will be able to access your medical information through the NC HealthConnex. Your NC HealthConnex data may also be provided to third parties who have entered into contracts with the NC HIEA for limited purposes (i.e. the NC Department of Public Health for immunizations). These contracts ensure that all relevant privacy statutes and regulations are followed in how your health information is viewed, used, and shared. The NC HIEA also has the power to audit the use of patient information by each participating practice and each third party to ensure the law is being followed.

Right to Opt Out of NC HealthConnex

You have the right to opt out of having your information shared between providers through NC HealthConnex. If you choose to opt out, please fill out the form on the following page and mail it to the NC HIEA. Opting out of NC HealthConnex will not adversely affect your treatment by your physician and you cannot be discriminated against if you to decide to opt out. You can also use the form to rescind a previous opt-out if you change your mind. However, your information may also be shared as required or permitted by law, for instance, for public health purposes.

Please note that the NC HIEA will only process opt out forms that are signed by adults over the age of 18. If you are under the age of 18 and have not gone through the legal process to become emancipated, you must have a parent or legal guardian sign the opt-out form.

The information presented is not legal advice and is not to be acted on as such, may not be current, and is subject to change without notice.

NC HealthConnex
Powering Health Care Outcomes

North Carolina Health Information Exchange Authority
Patient Opt-Out Form

Please complete one box and the information requested below, and mail to:
NC HIEA, Attn: Opt-Out Processing, 4101 Mail Service Center, Raleigh, NC 27699-4101 Please include a return address on the mailing envelope.

☐ **Opt-Out: The NC HIEA may not share any of my health information.**

By completing and signing this form, I certify that I have been notified of the benefits of NC HealthConnex and of my right to opt out of having my data shared between participating health care providers through NC HealthConnex. I also understand that my personal health information may be accessed and used in certain circumstances pursuant to HIPAA and NC law, such as reporting public health threats. **I understand that the information provided to me is not legal advice and I will hold the North Carolina Health Information Exchange Authority harmless for the direct or indirect consequences of my decision to opt out.**

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____
Print Name

☐ **Rescind Opt-Out: I request to terminate my previous decision to opt out.**

By completing and signing this form, I am allowing my health information to be accessible to my health care providers through NC HealthConnex as permitted or required by North Carolina or federal law.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____
Print Name

Please complete all of the following fields for the patient who is requesting the opt-out or the opt-out rescission. Incomplete forms will not be processed.

_____
First Name of Patient Middle Name Last Name

_____ _____
Street Address Mailing Address

_____ _____
City State Zip City State Zip

_____/_____/_____ _____ _____
Date of Birth Sex Email

(_____)_____ (_____)_____
Primary Phone Number Secondary Phone Number

OUTREACH MANAGEMENTSERVICES, LLC

Client Name:_____ DOB:_____MCD/Ins:_____Client#: _____

Orientation Checklist

Your signature below indicates that you have received and fully understand the below listed Items:

1. Received a verbal explanation of Outreach Management Services mission statement. Programs/services provided, hours of operation and access to after hour services.
2. Received information regarding the right of the consumer to make informed decisions and have a choice when selecting a service provider.
3. Been provided a copy of the rules/expectations for the program/service being admitted to.
4. Received an explanation of:
   - Consumer Rights
   - Consumer Input Regarding the Service Quality, Satisfaction with the Service
   - Received and Achievement of Outcomes
   - Complaint/Appeal Procedures
   - Consumer Confidentiality and Protected Health Information
   - Employee Ethics
   - Right to serve on agency Human Rights Committee, and opportunities to provide input to agency treatment protocols including medical necessity and Best Practice
   - Consumer Search and Seizure Procedures
   - Any Restrictive Procedures That Might Apply (Behavioral Management Procedures, including purpose, goals, reinforcement structure, emergency restrictive interventions, and notification of parent and/or guardian)
   - Tobacco Use, Illicit/licit drugs, and possession of weapons
   - Abuse and Neglect
   - Requirements for follow-up for the mandated person served, regardless of his or her discharge outcome
5. Received a verbal explanation of the specific services you will receive from Outreach Management Services and an estimated timeframe for the need for services.
6. Explanation of financial obligations, fee assessment and collection practices, and financial arrangements for services provided.
7. Been informed of the procedures for developing/implementing person-centered treatment assessment/planning with the active involvement of persons served and identified parent/guardian/significant other.
8. Been informed of the Right of Accessibility and Removal of Barriers.
9. Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the person served.
10. Means by which the person served may regain rights or privileges that have been restricted
11. Received information regarding suspension, expulsion, and discharge criteria and the transition/discharge planning process, including the active involvement of the person served.
12. Agree to attend all scheduled appointments, confirm appointments within 48 hours if appointment date, participate in treatment, and if appointments must be canceled will provide at least 24-hour advance notice. Failure to participate/comply with treatment may result in a treatment team review and possible discharge or referral to another program/service.
13. Received a tour of premises and been informed of emergency procedures and equipment.
14. Received Advance Instruction for Mental Health Treatment
15. Your rights under the Health Insurance Portability and Accountability Act.
16. I consent to a UDS.
17. When applicable, an explanation of the organization's services and activities include:
    - Expectation for consistent court appearances
    - Identification of therapeutic interventions, including: Sanctions - Interventions - Incentives - Administrative discharge criteria.

The assigned professional responsible for coordinating your services is:

Name_____Title_____Phone_____

Have had all questions answered in a manner that you understand.

_____ _____

Consumer Signature Admit Date Staff Signature Admit Date

_____

Parent/Guardian Signature Admit Date

OUTREACH MANAGEMENT SERVICES

Client Name:_____MCD/Ins.#:_____Client#:_____DOB:_____

AUTHORIZATION FOR DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

I hereby request and authorize **OUTREACH MANAGEMENT SERVICES** to disclose to, receive from, and communicate with:

- ☐ NCTOPPS
- ☐ DEPARTMENT OF SOCIAL SERVICES
- ☐ DEPARTMENT OF JUVENILE JUSTICE
- ☐ SCHOOL _____
- ☐ HOSPITAL _____
- ☐ OTHER _____

The following protected information: (please initial each that applies/mark N/A if not required)Assessment

_____Psychological Evaluation
_____Treatment Plan & Diagnosis
_____Discharge Summary
_____Progress Notes
_____Financial Information
_____Substance Abuse Information
_____Psychiatric Evaluation
_____Acquired Immunodeficiency Syndrome (HIV)
_____Medical History
_____Education Information
_____Other:_____

The purpose of disclosure is: CONTINUED COORDINATION OF CARE
Specific purpose for information

The date this consent expires: 365 days from date of client signature below .

Redisclosure of protected health information is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" for substance abuse treatment and under state law G.S. 122C for mental health and developmental disabilities.

I may revoke this authorization at any time. I understand that any action taken on this authorization prior to the date I revoke it is legal and binding. I understand I may revoke this authorization by writing a letter or verbally telling the Partnership staff person I work with or by calling the Privacy Officer.

I certify that this authorization is made freely, voluntarily, and without coercion. I may refuse to sign this authorization form and OUTREACH MANAGEMENT will not condition my treatment on receiving my signature on this authorization.

_____ _____
Client or Personal Representative Signature Date

_____ _____
Parent/Guardian if client under 18 Date

_____ _____
Staff Signature Date

REVOCATION OF AUTHORIZATION/CONSENT

I WITHDRAW THE AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION OF _____
(Verbal Request by: _____) effective on: _____

_____ _____
Client or Personal Representative Signature Date

_____ _____
Parent/Guardian if client under 18 Date

_____ _____
Staff Signature Date

PARTNERS
Behavioral Health Management

Authorization for Use, Disclosure, and Exchange of Protected Health Information

Client Name:		DOB:
Medicaid ID:	Partners BHM ID:	Previous LME/ID:

I, _____, do hereby authorize Partners BHM and
Client or client representative

OUTREACH MANAGEMENT SERVICES, Located at 1723 ARMSTRONG PARK DR, GASTONIA, to 704-854-9828/704-917-7610
Name of Agency that information is to be shared with *Address/Phone number of Agency information is to be shared with*

share the following protected Health Information:
Please be specific when requesting. Data covers the time period of _____to _____. Data authorized for release may include the following (initial if applicable)

_____ Alcohol/Drug treatment
_____ Diagnostic Information
_____ Financial/Reimbursement
_____ Hepatitis
_____ Human Immunodeficiency Virus (HIV)
_____ Intake/Assessment
_____ Medication Information
_____ Progress/Service Notes

_____ Psychological/Psychiatric Evaluations
_____ Screening/Contact Assessment
_____ Service/Treatment Plan
_____ Tuberculosis
_____ Other/Disclosures to include _____

The Purpose of the disclosure is(check which are applicable):

__X__Service Delivery __X__ Continuity of Care_____ Referral_____ Disability_____Other(specify)_____

RE-DISCLOSURE: Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law (45 CFR Part 164) may not apply to the recipient of the information and, therefore, may not prohibit the recipient of the information from re-disclosing it. Other laws, however, may prohibit re-disclosure. When information is released from this agency protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42 CFR, part 2), the recipient of the information is informed that re-disclosure is prohibited except as permitted or required by *these two laws.* Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION and EXPIRATION: I understand that, this authorization may be revoked in writing at any time, except where action has already been taken on this authorization. The process for how to revoke this authorization, as well as the exceptions to my right to revoke, are explained in Partners Behavioral Health Management Notice of Privacy Practices, a copy of which has been provided to me.
If not revoked earlier, this authorization to disclose expires on:_____
Not to exceed one year from date of signature

Notice of Voluntary Authorization: I understand that I may refuse to sign this form. If I choose not to sign this form, I understand that Partners Behavioral Health Management cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits based on my refusal to sign unless the provision of health care is *solely* for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party. I understand that my signature is voluntary on this authorization and that I may request a copy of it once I have signed it.

Signature of Client *Date* *Printed Signature of Client* *Date*

Signature of Client Legal Representative -- if client unable to sign *Date* *Printed Signature of Client Legal Representative* *Date*

Client Legal Representative relationship to client

01/12

Member Name: _____ Date of Birth _____

Behavioral Health Provider/Primary Care Physician Communication Form

Member Consent to Exchange Information (to be completed by member)

I, _____, authorize/do not authorize _____
(print name) (circle one) (provider's name)

My behavioral health provider, and _____, _____
(PCP name) (PCP address and phone number)

to exchange information regarding my mental health /substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

_____ _____
I Authorize Communication between My PCP and Behavioral Health Provider (Member's Signature) **Date**

_____ _____
I Do Not Authorize Communication between My PCP and Behavioral Health Provider (Member's Signature) Date

_____ _____
Signature of parent or guardian (if member is a minor) Date

_____ _____
Witness Date

Provider Information (to be completed by *Outreach Management Services*) - Please Print

_____
Practitioner Name(s) (Therapist and Psychiatrist if applicable) | Address | City/State | Telephone Number

ICD 10 Diagnosis code & name _____

Treatment Plan: Type_____ Frequency _____ Est length of Tx _____
(I.e. ind, family, group, meds) (i.e. weekly, etc)

Medication(s) Prescribed: _____

_____

Comments:_____

For urgent or emergency situation, please call the primary care physician in addition to sending form.

☐ Conclusion of mental health/substance treatment
☐ Date of last session _____ Treatment completed? Yes___ No___
☐ Notification of prescription or change in medications (see comments)
☐ Other: _____

_____
Print Clinician **Name Signature/Credentials** **Telephone Number**

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGINAL IN THE MEMBER'S CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATION THAT FAX WAS SENT. _____ _____
DATE SENT **SENT BY (CLINICIAN PLEASE INITIAL)**

Please Check Method: ____FAX ____MAIL

Member Name: _____ Date of Birth: _____

Primary Care Physician/Behavioral Health Provider Communication Form

Please complete the following information regarding the person listed on page 1 and forward to Outreach Management Service behavioral health provider: 1723 ArmStrong Park Drive GaStonia, NC 28054 Phone: 704.854.9828 Fax: 704.854.9882

Provider Information (to be completed by Primary Care Physician) - Please Print

Physician Name(s) Address City/State Telephone #

Medical History: _____

_____

_____

_____

Medication(s) Prescribed: _____

_____

_____

Comments: _____

_____

_____

_____

Signature/Credentials **Date**

SEND A COPY OF THIS FORM TO OUTREACH MANAGEMENT SERVICES RETAINING THE ORIGINAL IN THE PATIENT'S CHART.

_____ _____ **Please Check Method: ____FAX ____MAIL**

DATE SENT **SENT BY (PCP OFFICE STAFF SIGNATURE)**

BELOW IS COMPLETED BY OUTREACH MANAGEMENT SERVICES UPON RECEIPT OF COMPLETED PAGE 2 FROM PRIMARY CARE PROVIDER

The information on the Primary Care Physician/Behavioral Health Provider Communication Form has been reviewed by:

_____

Attending Practitioner (print name) signature date

_____

Medical Director (print name) signature date

OUTREACH MANAGEMENT SERVICES, LLC
ADMISSION EVALUATION/SCREENING

Client Name:_____ MCD/Ins.#:_____ Client#:_____

Admit Date:_____ Referred by:_____

Reason For Admission: (As stated by client or others. Include Identification of Immediate care needs related to Psychiatric DX)

_____
_____
_____
_____

Treatment Recommendations:(If Partial Hospitalization, Include an explanation as to why client would be at risk for hospitalization if PH was declined):

_____
_____

Presenting Problem(s):

_____
_____
_____
_____
_____
_____
_____

Current Suicidal/Homicidal Ideations:_____ **If yes, attach PLAN FOR SAFETY**
Date of last Suicidal/Homicidal Thoughts:_____
Access to Weapons: (If yes, explain safety protocol):_____
Education History:_____
DSM-V Admitting Diagnosis:_____Other Diagnoses:_____

Staff Signature_____Admit Date_____

Staff Signature_____Admit Date_____

Staff Signature_____Admit Date_____

Staff Signature_____Admit Date_____

Staff Signature_____Admit Date_____

Medications (Including OTC's, Herbal or Alternative)	Dosage	Directions

FOR PROFESSIONAL USE ONLY

OUTREACH MANAGEMENT SERVICES, LLC

Client Name_____ DOB_____

Consumer Choice Selection: OUTREACH MANAGEMENT SERVICES

Other Choices Offered:

1. _____
2. _____
3. _____

Consent for Services:

I agree to participate in the treatment, services and support that are provided by Outreach Management Services, LLC 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.

I agree to accept the following checked services for Outreach Management Services, LLC.

- □ Community Support Team
- □ Partial Hospitalization Adolescent
- □ Partial Hospitalization Adult
- □ SAIOP Adolescent
- □ SAIOP Adult
- □ Intensive In-Home
- □ Outpatient Therapy
- □ Medication Management
- □ Tailored Care Management (checked by Care Manager only)
- □ Peer Support Services
- □ Tenancy Management Services

EMERGENT_____
URGENT _____
ROUTINE _____

_____ _____
Client Signature Admit Date

_____ _____
Parent/Guardian Signature Admit Date

_____ _____
Staff Signature Admit Date

TO BE COMPLETED WITH THE CLINICIAN

OUTREACH MANAGEMENT SERVICES, LLC
ACCOUNTING OF DISCLOSURE
INFORMATION DISCLOSED

Client Name:_____ MCD/Ins.#:_____Client #:_____

DATE	RECIPIENT	SPECIFIC INFORMATION DISCLOSED	REASON FOR DISCLOSURE	METHOD OF DISCLOSURE	FULL SIGNATURE

TO BE COMPLETED BY PROFESSIONAL ONLY

Outreach
Management Services
Prevention. Intervention. Treatment.

Transition Planning Form

Client Name: _____MCD/Insurance#_____Client#_____Admission Date:____

Diagnosis at Admission:
1.
2.
3.

Summary:

Presenting Condition: **Please refer to the Admissions Eval page in the intake packet**

Strengths: **Please refer to CCA page 2** Needs: **Please refer to CCA page 2**

Transition Plan:

Reason for Transition: ☒ **Initial Discharge Planning and** ☒ **Plan for Treatment Services**

Support systems or other types of services that will assist in continuing the client's recovery, well-being, or community integration: _____
_____

Recommendations for Services or Supports:
_____
_____

Referral Information and Follow- Up Appointment(s): (who/when/where)

☐ Psychiatric _____
☐ Medical _____
☐ Therapy _____
☐ Substance Abuse Services _____
☐ Support Group_____
☐ Other OMS Service _____
☐ Other _____

I have participated in this transition plan, sharing my preferences and expectation.

Comments: _____
_____
_____

TO BE COMPLETED BY CLINICAN ONLY

Client Name:_____ DOB:_____MCD/Ins:_____Client#:_____

Discharge Summary

Date of Admission: _____ Discharge Date_____ ☐ Planned ☐ Unplanned and/or AMA

Admission Diagnosis

Discharge Diagnosis

Summary:

Services Provided:

☐ Diagnostic Assessment ☐ Substance Abuse Assessment ☐OPT ☐ CTI ☐TMS ☐IS
☐ Medication Management ☐IIH ☐ CST ☐ Partial Hospitalization ☐ SAIOP ☐ PSS
☐ Integrated Health Evaluation

Presenting Condition: _____

Summary (extent) of PCP Goal and Objectives achieved:

Progress/Gains made during services: _____

TO BE COMPLETED BY PROFESSIONAL ONLY

Client Name:_____ DOB:_____MCD/Ins:_____Client#:_____

Reason for Discharge: ☐ Planned ☐ Unplanned and/or AMA

(Check only one from items below)

	Program Graduation and/or Completion of Treatment Goals		**Evaluation Complete**
	Step-Down, stabilized at current level of care		**Refusal of Service / Treatment**
	Inappropriate level of Care / Service Not Available - Need to refer out		**Moved out of Area**
	Abandonment of Services: *(cannot locate, chronic no show, etc)*		**Death**
	Other: **Please specify:** _____		

If unplanned: Please describe planned follow up, notification provided (to consumer), and reason for unplanned discharge. _____

_____

_____

_____

_____

_____

Did we offer consumer referral for other service? _____

_____

_____

Status of Consumer at last contact: (check all that apply)

☐ **Stable, cooperative, motivated**
☐ **Functioning with supports / treatment in place**
☐ **Non- Compliant or Not responding to treatment**
☐ **Severe Symptoms, risk to self/others**
☐ **Refusal of service**

Residence Type at time of discharge:

☐ Private Home – persons in home (relationship):_____
☐ ALF/Residential/Group Home/Halfway House: _____
☐ In-Patient Psych/State Hospital/Medical Hospital: _____
☐ Foster Care Placement: _____
☐ Jail/Prison/Detention: _____
☐ Other: _____

TO BE COMPLETED BY PROFESSIONAL ONLY

Client Name:_____ DOB:_____MCD/Ins:_____Client#:_____

Medications at time of discharge, including OTC's herbal or alternative (name/dosage/frequency)**:** _____
_____
_____
_____
_____

Recommendations for Services and Supports: _____
_____
_____
_____
_____

Support systems or other types of services that will assist in continuing the client's recovery, well-being, or community integration: _____
_____
_____

Person(s) Responsible for Coordinating Discharge:
_____
_____

Integrated Behavioral Health Discharge Recommendation and Appointment(s): (who/when/where)

☐Psychiatric _____
☐Psychological _____
☐Medical _____
☐Complimentary Health _____
☐Therapies _____
☐Substance Abuse Services _____
☐Support Group /Community Program _____
☐Other OMS Service _____
☐Other _____

TO BE COMPLETED BY PROFESSIONAL ONLY

Client Name:_____ DOB:_____MCD/Ins:_____Client#:_____

Other Comments pertaining to Course of Treatment:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of OMS Staff Completing Plan Date

_____ _____

Clinical Supervisor Signature Date

** For OMS Use Only **

Note: This plan was completed upon review of consumer transition plan (please see copy of same in consumer record) and readiness for discharge from treatment. This discharge summary will be forwarded, along with current consumer treatment plan; to Primary Health Care Provider or other entity within ***(2)*** *working days, as applicable.*

TO BE COMPLETED BY PROFESSIONAL ONLY

Client Name:_____ DOB:_____MCD/Ins:_____Client#: _____

If my symptoms should recur or if I need any other Integrated Behavioral Health or Primary Care, services I will call: Outreach Management Services at (704) 854-9828, (704) 917-7610 or Partners BHM at 1-888-235- HOPE (4673).

_____ _____
Client Date

_____ _____
Legal Guardian/Parent Date

_____ _____
OMS Staff Completing Plan Date

_____ _____
Clinical Supervisor Date