Client Name: ______________________________
ID#: ______________________________
DOB: ______________________________

Receipt of the CarePlus Consumer Handbook

The CarePlus NJ Consumer Handbook contains an overview of policies and procedures including but not limited to:

- Overview of Services & Point of Access; Business Hours including Inclement Weather
- Client Bill of Rights including Treatment Rights and Notice of Privacy Practices
- Use & Disclosures of Protected Health Information for the purposes of Treatment, Payment and Healthcare Operations
- Grievance Procedure
- Family Involvement Policy
- Use of Health Information Exchanges
- Methods of Communications
- Fee Agreement, including Cancellation & Missed Appointment Policy
- Transportation: including permitting Care Plus to acknowledge my presence when I use external transportation services

I acknowledge that I have received this information and have the opportunity to ask questions at any time.
Check off each of the following to acknowledge or write N/A (not applicable) if N/A based on age.

Authorized Person's Initials *	**Informed Consent Information Topics:**
	Psychiatric Advance Directive for Mental Health (**PAD**): At this time, ☐ **I do** ☐ **I do not** have a Psychiatric Advance Directive and ☐ ***I do*** ☐ ***I do not*** wish to utilize resources provided by CarePlus regarding this matter. I understand that in compliance with NJ State regulations, I may be asked about a PAD each time that my treatment plan is reviewed.
	Wellness & Recovery Action Plan (WRAP): At this time, ☐ ***I do*** ☐ ***do not*** have a Wellness & Recovery Action Plan **and** ☐ **I do** ☐ **do not** wish to utilize resources provided by CarePlus regarding this matter. I also understand that I may be required to develop a WRAP as required by State regulations governing a program in which I may participate.
	Minors, including Permission to Treat a Minor: Consent: I hereby consent & give my permission for the above named minor, to receive treatment at CarePlus. I further certify that I have legal custody of this person and I am in the position of being able to such consent. **I understand that if I am not the natural parent, or I am separated or divorced from the other natural parent, I must provide documentation of my legal custody of the above named minor. I also understand that a minor may voluntarily give consent for Substance Use and Reproductive Health treatment, and that the minor may have control of the minor's Substance Use treatment records in the same manner as an adult.** ☐ *Not Applicable, **Not a minor or emancipated***
	Student Interns / Licensed Staff: We reserve the right to use master-level student interns as well as licensed staff. These students / staff are supervised by a clinical supervisor. **In Case Management programs, staff may be bachelor-level. All direct service staff meet the qualifications delineated in State regulations. You have the right to be informed about the credentials of the staff providing you services / treatment.**

Insurance RELEASE: **"I authorize CarePlus NJ to release information to my insurance company / plan:**
Company / Plan Name:____:

For the purpose of billing and reimbursement for services rendered. This includes date, time, type of services, diagnosis and/or condition requiring treatment including alcohol and/or substance abuse, the name of the person receiving treatment and/or responsible for payment. This includes **clinical documentation necessary to support the services provided and/or reimbursed in response to periodic audits.** Payments are to be made directly to CarePlus NJ. I am responsible to pay any amounts paid to me in error. I understand that I am responsible for any co-payments, deductibles and/or any fees contracted for services provided to me. ***I understand that if I am not the person identified as the plan's insured individual, information about services billed will be included in the Explanation of Benefit's (EOB) issued to the insured individual. Example: Spouse, Adult Child & Parent.*** I understand that I have the right to restrict release of my information to my insurance and, in so doing, I am responsible for payment in full for services received.

Authorized Signature: ______________________________ **Date:** ________________

By signing this document, I am confirming that I have been offered and/or received the CarePlus NJ Consumer Handbook and that I understand the terms and conditions regarding care as outlined in this CarePlus NJ Handbook including the Notice of Privacy Practices.

______________________________ ______________________________
(Signature of Client/Authorized Parent/Guardian/Representative) ***(Date)***

If client refuses to sign, specify: ______________________________