Client Name: _____

ID#: _____

Receipt of the Care Plus Consumer Handbook

The Care Plus 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
- Grievance Procedure
- Family Involvement Policy
- Methods of Communications

Furthermore, I acknowledge that I have received the following information contained in the handbook and had the opportunity to ask questions. (Check off each of the following to acknowledge receipt and understanding)

Authorized Person's Initials *	**Informed Consent Information Topics:** *The authorized person shall initial each item to document review and understanding of that topic. Client or Staff shall indicate "N/A" for any topic that does not apply.
	Fee Agreement; Cancellation/Missed Appointment Policy
	Transportation: I authorize Care Plus to acknowledge my presence when I use external sources for transportation.
	Use and disclosure of Protected Health Information (TPO) and Electronic Communications Consent: Care Plus reserves the right to communicate via email or text notifications unless I sign off on the "Alternate Communications" form advising otherwise. I understand that under TPO, Care Plus is required to submit specific data, including but not limited to, admission/transfer/discharge, encounter data, units of service, treatment services, program goals & objectives & outcome measures to the State of NJ DMHAS, DCF, and SAMHSA.
	HIE /HIO Consent: I consent to participate in the exchange of my PHI through an HIE / HIO. I authorize Care Plus to release my PHI to the HIE / HIO & allow other providers in the HIE to access my information. I have been informed about the HIE / HIO through which my PHI will be exchanged, what PHI will be exchanged, and the status of my PHI in the event that I opt out of the HIE / HIO at a later date. If I choose to opt-out, I understand I can contact the Care Plus Privacy Officer.
	Telehealth: I may choose to receive services via Telehealth. I understand that I will receive my Telehealth session link via email and/or text based on my preference. By agreeing to receive services via Telehealth, I am consenting to the terms of this arrangement.
	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 Care Plus 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 Care Plus 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 Care Plus. 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.**

By signing this document, I am confirming that I ☐ have been offered / ☐ received the Care Plus Consumer Handbook and that I am in agreement with the terms and conditions regarding care as outlined in this Care Plus Handbook including the Notice of Privacy Practices.

_____ _____

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

If client refuses to sign, specify: _

Insurance RELEASE: "I authorize Care Plus to release information to my insurance company/plan:

Company / Plan Name: _____:

For the purpose of billing and reimbursement for services rendered This includes the 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 also includes **clinical documentation necessary to support the services provided and/or reimbursed in response to periodic audits**. Payments are to be made directly to Care Plus NJ I am responsible for paying 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 also 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 the release of my information to my insurance and, in so doing, I am responsible for payment in full for services received.

Authorized Signature: _____ **Date:** _____