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 and Points of Access; Business Hours, including inclement weather:
- Client Bill of Rights, including Treatment Rights; Notice of Privacy Practices:
- Use and disclosures of Protected Health Information for the purposes of Treatment, Payment and Healthcare Operations (TPO):
- Grievance Procedure:
- Family Involvement Policy:
- Use of Health Information Exchanges:
- Telehealth:
- Methods of Communication:
- Fee agreement, including cancellation and missed appointment policy:
- Transportation, including permitting Care Plus to acknowledge my presence when I use external transportation services.

I acknowledge that I have received the following information contained in the handbook and had the opportunity to ask questions. (Initial 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, based on age.
	Confidentiality Policy and Procedure for Release of Information/Notice of Privacy Practices
	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: CarePlus reserves the right to communicate via email or text notifications unless I sign off on the Alternate Communication 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 Division of Mental Health & Addiction Services (NJ DMHAS), Department of Children & Families (DCF), and the Substance Abuse & Mental Health Services Administration (SAMHSA).
	Consent to Record: It is our policy that recording any sessions, (including but not limited to therapy, case management) without permission of the Care Plus staff (including but not limited to therapist, prescriber, case manager) is strictly prohibited. This policy ensures that the therapeutic space remains a secure and confidential place for open communication. Care Plus staff is committed to uphold your privacy and would never record sessions without prior consent. I acknowledge that I will respect their privacy and the integrity of our therapeutic relationship and will not record without prior consent.
	HIE /HIO Consent: Care Plus participates in one or more electronic health information exchange organizations ("HIE, HIO"), designed to facilitate the availability of your health information electronically to healthcare providers who provide you treatment. You will be required to complete a separate authorization form to reflect your decision to either participate or opt out.
	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.
	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.
	Psychiatric Advance Directive for Mental Health (**PAD**): At this time: ☐ **I do** have a Psychiatric Advance Directive ☐ **I do not** have a Psychiatric Advance Directive and ☐ **I do** wish to utilize resources provided by Care Plus regarding this matter. ☐ **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): is a prevention and wellness tool that anyone can use to get well and stay well. WRAP can be used to address all kinds of physical health, mental health, and life issues. WRAP can help you identify your own wellness tools: develop a list of things to do every day to stay as well as possible: identify early warning signs that things may have gotten worse: develop an action plan utilizing your strengths and wellness tools: create a crisis plan and post-crisis plan. Having a WRAP plan is voluntary. 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 abovenamed minor, to receive treatment at CarePlus NJ, Inc. I further certify that I have legal custody of this person and am in the position of being able to give 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 abovenamed 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,* as client is an adult ☐Client/Authorized Parent/Guardian

By signing this document, I am confirming that I have been offered and/or 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)**

_____ _____
(Printed Name of Client/Authorized Parent/Guardian/Representative) **(Relationship to Client)**

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. Iam 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 Benefits (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 Printed Name: _____ **Date:** _____

Authorized Signature: _____

Relationship to Client: _____