Rim Family Services

"Preserving Our Families... Strengthening Our Communities"

IMMEDIATE NEED
PROWELLNESS ACADEMY

Date: _____ Time: _____

Name: _____ Age: _____

Gender: _____

Mailing Address:

_____
_____
_____

Home Phone: _____ Email: _____
Cell Phone: _____

ProWellness Reporting:

- ☐ Yes, send to mhunt@rimfamilyservices.org
- ☐ No, rural community member referral only

Program:

- ☐ Other (Non-RFS Funded)
  - ☐ Has MediCal
  - ☐ Has Insurance

Diagnosis and/or Presenting Issue:

_____
_____
_____
_____

Know Medication / Substances:

_____
_____
_____
_____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS

I, _____, hereby authorize RIM FAMILY SERVICES, Inc. to
(Print clients name, if minor, parent's name)
disclose verbal or written information and records pertaining to my program(s) participation or my minor's

program(s) participation (_____) to the following checked
(Minor's name if applicable)
agencies or individuals:

- ☑ Agency intra-staff communication to foster optimum treatment
- ☐ SELPA
- ☐ Department of Alcohol and Drug Programs
- ☐ Department of Behavioral Health
- ☐ Department of Children and Family Services
- ☐ Rim of the World Unified School District
- ☐ My personal attorney: _____
- ☐ My personal physician: _____
- ☐ Other: _____

I specifically authorize release of the following information (check as appropriate):

- ☐ Mental Health Treatment Information
- ☐ Alcohol/Drug Treatment Information
- ☐ Only the following records or types of information (include any dates):
  _____ _____

The disclosure of confidential information and/or records herein authorized is required for the purpose of establishing or determining my status, progress, and/or compliance with the terms and conditions of my program(s).

This release of confidential information and/or records shall remain in effect until: _____.
(Must enter date)
I further understand that Rim Family Services, Inc. employees are mandatory reporters and do not need my written consent to release information under the following conditions:

1. Child, Elderly, Infirm Abuse (i.e. Sexual, Physical, Emotional, Neglect) observed or reported.
2. To prevent bodily harm to another person.
3. To prevent a Serious Threat to Health or Safety. We may use and give your private health information to prevent a serious threat to your health and safety or to the health and safety of the public or another person.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

Client Signature Date RFS Staff Signature Date

CONSENT FOR TREATMENT/LIMITS OF CONFIDENTIALITY

I_____, give consent for enrollment in counseling services provided by **Rim Family Services, Inc.** and confirm that I am not enrolled in any other program at this time. All information which I have given is true to the best of my knowledge.

I have been made aware that only an authorized person(s) will have access to my file and that no records, statements or data contained therein may be used to prosecute, charge, or otherwise infringe upon my civil rights. Thus, the confidentiality of my records has been assured to me as stipulated by 42 CRF, Part 2 and Article 7 (commencing with Section 325) of Subchapter 2 , Part 1 of Division 5, Welfare and Institution Code. Furthermore, I have been made aware that my written authorization is needed before any confidential information is released, except under the following conditions:

1. Child Abuse is observed or reported
2. Elderly or infirm abuse is observed or reported
3. To prevent bodily harm to another person
4. To prevent self-inflicted bodily harm
5. Agency intra-staff communication to foster optimum treatment

TELEPHONE CONTACT

My counselor may contact me by phone at: Work _____ Home_____ Other (please specify_____
A message identifying the: Counselor_____ Rim Family Services_____, may be left at; Work_____ Home_____ Other_____

PROGRAM POLICIES AND REGULATIONS

1. No alcohol/drug dealing, use or induced behavior.
2. No threats of or actual physical violence.
3. No smoking in the building.
4. Dress Code: No sleeveless shirts, no bare midriffs or cleavage; pants must be worn to the waist; no undergarments showing at any time; no clothing or accessories with derogatory/alcohol/drug/gang/sexual slogans; no hats or sunglasses worn indoors; shorts and skirts must be to the knee; no other inappropriate clothing or accessories allowed.
5. Regular payment of determined fee is expected at time of service.
6. Confidentiality regarding other clients is of the utmost importance.
7. Advance notice is expected if you cannot keep an appointment. Less than 12 hours notice for an individual appointment may result in partial or full fee charge. Being on time for appointments is expected.
8. Perceived problems in the counseling relationship should be discussed immediately with your counselor.
9. The Agency is closed on major holidays and for occasional staff training. Notice will be posted.
10. Office hours are 9:00am to 6:00pm, Monday through Friday. The answer machine and FAX are always on.
11. Inclement Weather Policy: If you feel it is unsafe to attend class due to poor road conditions, contact the Agency for instructions. If the Agency is closed for any reason, there will be a recording on the answer machine.

GRIEVANCE AND NON-DISCRIMINATION

Rim Family Services, Inc. reserves the right to terminate client participation for non-compliance, giving verbal and written notice of cause. The client has the right to appeal termination, or any other grievance resulting from program participation, by submitting a written statement to the Executive Director who will respond within three business days. Rim Family Services pledges no-discrimination on the basis of race, ethnic origin, age, gender, religion or disability.

_____ _____
Client Signature Date Counselor's Signature Date

_____
Parent/Guardian Signature Date

PROWELLNES ACADEMY

HIPAA*

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please Print Clearly and Complete in its Entirety.

I hereby authorize ProWellness Academy Counseling Services, to disclose my Personal Behavioral Wellness and/or Addiction Health Information to any of my Referring physicians, hospitals and/or facilities that work with ProWellness Academy collaboratively with any of my necessary treatments, assessments, or service. I also hereby authorize ProWellness Academy to be allowed to review, and/or make inquiry into my past or present coverages under my current Medical Health Insurance Plan:

Additional Disclosures are authorized by me for the following purpose/reason:

- To provide weekly summary counseling progress note assessments to any of my Referring Physicians, hospitals and/or facilities that work collaboratively with ProWellness Academy in my treatment and/or care.
- To assist me in inquiry about existing or possible new health Insurance coverages as it relates to Mental Wellness and/or addiction counseling toward my collaborative care.

Personal Health Information to be disclosed:

- ✓ I authorize ProWellness Academy to release my personal mental wellness information relating to my weekly counseling sessions, by way of a summary case notes, to my **RIM Family Services** % Authorized Staff Member:_____
- ✓ I authorize ProWellness Academy to make any and all inquiry as it relates to my current Medical Health Insurance coverages, as it relates to my Mental Wellness and/or addiction coverages; if any.
- ✓ My Health Insurance is with:_____
- ✓ Health Plan Member ID: _____

COVERED PERSON: Middle: Last: Name: (PRINT)	Patient SSN:_____ DOB: _____
Address: City: State: Zip: Phone:_____	Group# (if applicable)

By signing below, I acknowledge and understand that:

- This authorization is voluntary.
- I may revoke this authorization at any time by writing to ProWellness Academy, at the address above. If I do not revoke this authorization it will be valid until such time as I am no longer assigned to receive counseling from ProWellness Academy.
- My revocation will not apply to any action taken before ProWellness Academy receives it.
- My Personal Health Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the privacy rules of the U.S. Department of Health and Human Services.

Signed by Patient: X_____ Print Name:_____ Email:_____	Date :

ProWellness Academy; 2945 Townsgate Road; Ste. 200; Westlake Village, CA 91361

www.ProWellness.Academy

Office: 805.342.0222 **FAX 805.617.0183** info@prowellness.academy