Today's Date ___________

CLIENT INFORMATION

PLEASE PRINT

Client's Name: ____ Gender: ☐Male ☐Female
Last Name First Name Middle Name
Social Security #: _____________________ Client Mother's Maiden Name: ____
Age: ______ Date of Birth: ______________ Grade: __________ Highest Education Level: ______________________________
Street Address: ____
City: __________________________ State: ____________________ Zip: ____
School: ________________________ Birth City: _______________________ Birth Country: _____________________________

Ethnicity: ☐White ☐African American ☐Hispanic ☐American Indian/Alaskan Native ☐Chinese ☐Japanese ☐Filipino ☐Korean ☐Indochinese ☐Amerasian ☐Cambodian ☐Samoan ☐Asian Indian ☐Hawaiian Native ☐Guamanian ☐Location ☐Vietnamese ☐Hmong ☐Mien ☐Other: ____

Origin: ☐Mexico ☐Cuba ☐Puerto Rico ☐Central America ☐South America ☐Other: _________________________________
Mixed: ____________________________________ Unknown: ____
English Speaking ☐Yes ☐No Primary Language: ______________________ Preferred Language: _________________________
Is Client Homeless ☐Yes ☐No Is Client Handicap: ☐Yes ☐No If yes, describe: _______________________________________

Living Arrangement: ____
Private Insurance ID #: _______________________________________ Name of Insurance: ______________________________
Name of Policy Holder: _______________________________________ Date of Birth: __________________________________

Complete if Client is a Minor
Caregiver's Name: ____ Relationship to Client: _____________________
Last Name First Name
Legal Guardian ☐Yes ☐No Custody Arrangement: ____
Home Phone (_______)______________________ Cell Phone: (_______)____
Employment Status: _________________________ Email Address: ____

Emergency Contact Name: _______________________________________ Relationship to Client: ________________________
Emergency Contact Phone Number: ____

I affirm under penalty of perjury that the above mentioned information herein is true and correct to the best of my knowledge and if the child becomes a client of The Children's Center of the Antelope Valley, I agree to inform he office of any changes immediately.

Client/Caregiver Signature (if minor): ____ Date: _________________________

*45111 Fern Ave. · Lancaster, Ca 93534 · (661) 949-1206 Office · (661) 940-5452 Fax · **www.CCAV.org***

☐ID ☐SS Card

Staff Initials: ___________

MEDICAL RECORDS POLICY AND CONSENT

The standards below are the expectations required to request and/or release health information for current or previous clients of The Children's Center of the Antelope Valley. The Children's Center values your confidentiality and abides by all HIPAA regulations mandated by the Department of Mental Health contract(s).

Medical Records requests consist of obtaining and/or releasing client health information by:

- Release or disclose health records and/or information
- Obtain or use records and/or information
- Mutually discussing or exchanging records and/or information

MY HIGHLY CONFIDENTIAL INFORMATION

By signing my name next to a category of highly confidential information listed below on an Authorization form, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to an Authorization:

- Information about Mental Illness or Developmental Disability
- Psychotherapy Notes
- Information about HIV/AIDS Testing Diagnosis or Treatment
  (Including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such test were positive or negative)
- Information about Communicable Disease
- Information about Substance (i.e. alcohol or drug) Abuse, Prevention and Treatment
- Information about Sexual Assault
- Information about Child Abuse and Neglect
- Information about Genetic Testing
- Information about Domestic Abuse
- Information about Elder Abuse

RECIPIENT *– Name of person or class of person to whom The Children's Center may disclose my health information.*

TERM *– The duration of time an Authorization will remain in effect for.*

PURPOSE *– I authorize The Children's Center of the Antelope Valley to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of an Authorization for specific purpose*

I understand that once The Children's Center discloses my health information to the recipient, The Children's Center cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by any Authorization or applicable Federal and State law governing the use and disclosure of my health information.

I understand that The Children's Center may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may at any time make a written request to The Children's Center to inspect and/or obtain a copy of my health information, and that The Children's Center will within thirty (30) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information **for a fee of $25.00 per request and proof of positive identification (ID),** or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I have a right to receive a copy of an Authorization.

I understand that I may refuse to sign or revoke (at any time) an Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at The Children's Center; except, however, if my treatment at The Children's Center is for the sole purpose of creating health information for disclosure to the recipient identified in an Authorization, in which case The Children's Center may refuse to treat me if I do not sign an Authorization.

I understand that an Authorization will remain in effect until the term or an Authorization expires or I provide a written notice of revocation to The Children's Center's Privacy Office at the address listed below. The revocation will be effective immediately upon The Children's Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by The Children's Center in reliance on an Authorization before it received my written notice of revocation.

I may contact The Children's Center of the Antelope Valley's Privacy Office by mail at: 45111 Fern Avenue, Lancaster, CA 93534 or by telephone at (661) 949-1206.

I have read and understand the terms of an Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, understand The Children's Center of the Antelope Valley's policy to authorize the use or disclosure of protected health information in the manner which I describe on a signed Authorization form.

Client (Print Name) Signature of Client Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of personal Representative Description of Authority Date

Signature of Witness Date Client MIS# Provider Number

The Children's Center of the Antelope Valley
Attendance Policy

The guidelines below are the expectations required to continue as clients of The Children's Center.

1. **Children** and **adults** who are accepted into treatment at The Children's Center are expected **attend therapy** for **all scheduled appointments**.

2. In an **emergency** situation, The Children's Center will inform you by telephone if **a therapy session** must be **canceled** without prior notice. (If you **do not** have a **telephone,** please provide us with a **number in case of an emergency**.)

3. When you **know** of a **situation** that will cause you to **cancel** or **miss** an appointment, you must inform the therapist at least **24 hours in advance**.

4. You **are expected** to arrive for **therapy on time**. No one is admitted into therapy later **than ten (10) minutes** after the **start time**.

5. A **parent** or **guardian must remain** at The Children's Center during **all sessions** in case of medical emergency.

6. **Therapy** will **no longer be available** to you at The Children's Center after three **(3) absences** from your **regular therapy sessions**.

IMPORTANT: Therapy services will no longer be available to you at The Children's Center after three (3) unexcused absences from your regular scheduled therapy appointments. After 3 unexcused absences, your child will be discharged and all services will be terminated.

Name of Client (Print): ____

Name of Parent/Guardian: ____

Signature of parent/Guardian: ____

Date: ____

Agency Representative: ____ Date: ______________________

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PRIVATE INSURANCE CLIENTS ONLY

Patients Consent Use and Disclosure of health Information for Treatment, Payment, or Healthcare Operations in Accordance with HIPAA Requirements

The Children's Center originates and maintains records describing minor's health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment.

I/We understand that this information serves as:

- A basis for planning his/her care and treatment,
- A means of communication among the health professional who contribute to his/her care,
- A source of information for applying his/her diagnosis and information to the bill,
- A means by which his/her health plan can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence health professional.

It is understood that I have the following rights and privileges:

- The right to object to the use of his/her health information for directory purposes, and
- The right to request restrictions as to how his/her health information may be used or disclosed to carry out treatment, payment or healthcare operations.

It is understood that restrictions may be placed on how his/her health information is used. The Children's Center is **not** required to agree to restrictions requested. It is understood that this consent may be revoked in writing, except to the actions the organization may have already taken. It is understood that by refusing to sing this consent or revoking this consent The Children's Center may refuse to treat the minor.

I wish to have the following **restrictions** to the use or disclosure of the minor's health information:

____

____

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via FAX.

I fully understand and ☐**accept** or ☐**decline** (please check one) the terms of this consent.

____

Legal Guardian Date

____

Minor Witness