Client Name: _____

Male or Female (Circle one) Are you pregnant? Yes____ No ____

What is your Gender Identity? Male____ Female____ Gender Variant/Non–Conforming____
Transgender Female___ Transgender Male___ Prefer Not to Answer____ Not Listed _____

Description of Concern (Why you are coming in today): _____

_____

Guardian Name (if under 18): _____

Client DOB: _____

Client SS#: _____

Client Address: _____

Client Phone #: _____

Insurance Company and Policy# _____

Are you a Veteran? Yes__ No __ If under the age of 18, is the parent(s) a Veteran? Yes___ No ___

Appointment Reminders: Phone Call _____ Text Message _____ Email_____ All _____
Join the Patient Portal: Yes____ No_____

Email Address: _____

Race: _____ Hispanic or Latino ____ Not Hispanic or Latino ____

Emergency Contact Name/Number/Relationship:

_____

Pre-Screen

We're asking these questions because drug and alcohol use can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

Alcohol: One drink =

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Developed by SBIRT Oregon, http://www.sbirtoregon.org/resources/annual_forms/Annual%20-%20English.pdf

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

ELC Health Assessment Form

ELIZABETH LAYTON CENTER
For Hope and Guidance

Client Information: Date: _____

Full Name:	
Date of Birth:	
Height:	
Weight:	
BMI:	
Blood Pressure:	

Medical Conditions:

Do you have or have you had any of the following medical conditions?

CONDITION	YES	NO	CONDITION	YES	NO
ADHD/ADD			HIV/AIDS		
Alcoholism			HPV		
Allergies			Hypertension (Elevated Blood Pressure)		
Anxiety			Insomnia		
Asthma			Irregular or Rapid Heartbeat		
Cancer			Migraine Headache		
Congestive Heart Failure (CHD)			Obesity		
COPD			Pain or Pressure in Chest		
CVA/STROKE			Pregnancy		
Depression			Sleep Apnea		
Diabetes Mellitus			Substance Use		
Epilepsy			Tobacco Use		
HBV (Hepatitis B)			Urinary issues/incontinence		
Hepatitis C			OTHER:		

ELC Health Assessment Form

If yes on any of the above, please briefly explain and give an approximate date.

Family Medical History. Please list any family medical history in the table below.

Family Member	AGE	Diagnosis	If deceased, cause of death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling			
Sibling			
Other			

Do you have any concerns about your physical or mental health condition(s)? (Please circle)
YES or NO
If yes, please identify the condition(s) and concern(s) you have:

Have you seen your primary care provider in the last year? (Please Circle) YES NO

Have you had lab work done in the last year? (Please Circle) YES NO

Date of next appointment with a provider? _____

Do you need help setting up an appointment to see a medical provider? (Please Circle) YES NO

ELC Health Assessment Form

Are you currently taking any medications? (Please Circle) **YES** **NO** **SEE ATTACHMENT**
If yes, please list what medications and for what condition:

MEDICATION	DOSAGE	CONDITION

SOCIAL HISTORY: (Please Circle)
Do you exercise? **YES** **NO**
Type: (running, walking, water aerobics, biking, weights, core training, jazzercise, etc.)

_____
_____

How often? (Days a week and minutes)

_____

Do you have concerns about your weight or physical activity? (Please circle) **YES** **NO**
If yes, please explain your concerns

_____
_____
_____

******How many sugary drinks do you have per day?**

_____
_____

******How many unhealthy snacks do you have per day?**

_____
_____

PLEASE CIRCLE YES OR NO

Do you eat a well-balanced diet, most days? **YES** **NO**

Do you eat protein with most meals? **YES** **NO**

ELC Health Assessment Form

Reproductive and Sexual History (Please check all that apply.)

❒ You are between the ages of 15-79.

❒ You are pregnant.

❒ You are a sexually active with a man who has sex with other men.

❒ You or your sexual partner have had multiple sexual partners since your most recent HIV/Hepatitis/STI screening.

❒ You are currently receiving treatment for hepatitis, tuberculosis, or a sexually transmitted disease.

❒ Your sexual partner has HIV/Viral Hepatitis.

❒ You or your sexual partner use IV drugs.

❒ You or your sexual partner have exchanged sex for money or drugs.

Do you use tobacco, or have you used tobacco in the past? (Please circle) YES NO

If yes, type: ❒ Cigarettes ❒ Vape ❒ Chew ❒ Snuff ❒ Other_____

Amount per day? _____ Number of years_____ Last use _____

If you currently use, do you want/plan to quit? (Please circle) YES NO

Do you drink alcohol? (Please circle) YES NO
If yes, type(s) of alcohol_____

drinks per day_____ Drinks per week_____ Last use_____

If yes, do you want/plan to quit? (Please circle) YES NO

Do you use recreational drugs? (Please circle) YES NO
If yes, what do you use:
_____
_____

How do you use? ❒ Oral ❒ Smoke ❒ Intra Venous ❒ Other _____
If yes, do you want/plan to quit? (Please circle) YES NO

ELC Health Assessment Form

Are you part of a religious or spiritual community? (Please Circle) YES NO
If yes, how does that help you and what beliefs do you find most helpful?

Do you need assistance with any of the following: ❒ setting up appointments ❒ resources

❒ treatment ❒ vaccination(s) ❒ education on health & nutrition ❒ stop tobacco use

If yes to any of the above, please explain:

ELIZABETH LAYTON CENTER

For Hope and Guidance

MISSION OF THE ELIZABETH LAYTON CENTER

Elizabeth Layton Center provides comprehensive and integrated behavioral health services for our community.

Availability of Services: Services of our Center are available to all residents of Franklin County and Miami County regardless of race, color, sex, creed, handicap, religion or ability to pay.

STATEMENT OF CLIENT RIGHTS

To always be treated with dignity and respect, and not to be subjected to any verbal or physical abuse or exploitation;

To not be subjected to the use of any type of treatment, technique, intervention, or practice, including the use of any type of restraint or seclusion, performed solely as a means of coercion, discipline, or retaliation, or for the convenience of staff or any volunteer or contractor;

To receive treatment in the least restrictive, most appropriate manner;

To an explanation of the potential benefits and any known side effects or other risks associated with all medications that are prescribed for the client;

To an explanation of the potential benefits and any known adverse consequences or risks associated with any type of treatment that is not included in the aforementioned paragraph and that is included in the client's treatment plan;

To be provided with information about other clinically appropriate medications and alternative treatments, even if these medications or treatments are not the recommended choice of that client's treating professional;

The right of a client <u>voluntarily</u> receiving treatment to refuse any treatments or medications to which that client has not consented, in compliance with the client's rights;

The right of a client <u>involuntarily</u> receiving treatment pursuant to any court order to be informed that there may be consequences to the client if the client fails or refuses to comply with the provisions of the treatment plan or to take any prescribed medication;

To refuse to take any experimental medication or to participate in any experimental treatment or research project, and the right not to be forced or subjected to this medication or treatment without the client's knowledge and express consent, given in compliance with the client's rights, or as consented to by the client's guardian when the guardian has the proper authority to consent to this medication or treatment on the client's behalf;

To actively participate in the development of an individualized treatment plan, including the right to request changes in the treatment services being provided to the client, or to request that other staff members be assigned to provide these services to the client;

To receive treatment or other services from ELC in conjunction with treatment or other services obtained from other licensed mental health professionals or providers who are not affiliated with or employed by ELC, subject only to any written conditions that ELC may establish only to ensure coordination of treatment or any services;

To be accompanied or represented by an individual of client's own choice during all contacts with ELC. This right shall be subject to denial only upon determination by professional staff that the accompaniment or representation would compromise either that client's rights of confidentiality or the rights of other individuals, would significantly interfere with that client's treatment or that of other individuals, or would be unduly disruptive to ELC's operations;

To see and review the clinical record maintained on that client, unless the Executive Director of ELC has determined that specific portions of the record should not be disclosed. This determination shall be accompanied by a written statement placed within the clinical record required by K.A.R. 30-60-46, explaining why disclosure of that portion of the record at this time would be injurious to the welfare of that client or to others closely associated with that client;

To have staff refrain from disclosing to anyone the fact that the client has previously received or is currently receiving any type of mental health treatment or services, or from disclosing or delivering to anyone any information or material that the client has disclosed or provided to any staff member of ELC during any process of diagnosis or treatment. This right shall automatically be claimed on behalf of the client by ELC's staff unless that client expressly waives the privilege, in writing, or unless staff are required to do so by law or a proper court order;

To exercise the client's rights by substitute means, including the use of advance directives, a living will, a durable power of attorney for health care decisions, or through springing powers provided for within a guardianship; and

To at any time make a complaint in accordance with K.A.R. 30-60-51 concerning a violation of any of the rights listed in this regulation or concerning any other matter, and the right to be informed of the procedures and process for making such a complaint.

How to file a complaint or grievance concerning a violation of any of these rights, or any other matter of concern, with the Executive Director of the Center. Forms are available upon request from the receptionist or concerns may be voiced verbally.

1) Complaints can be made verbally or in writing to the Executive Director or QA Coordinator via the receptionist, treatment provider or by directly calling or writing the Executive Director or QA Coordinator. The Executive Director or QA Coordinator will investigate and respond to any complaint within one week under ordinary circumstances.
2) If the client is not satisfied with the way the complaint is handled, **or** if the complaint involves the Executive Director of this Center, a verbal or written complaint should be directed to: Privacy Officer or the ELC Board President.
    a) The complaint will then be investigated by the governing body of the Center and a disposition made no later than one month following receipt of the complaint. The client will then be contacted in writing of Board action taken on the complaint. The client may be represented by counsel or any other person(s) of their choice during the process of filing a complaint or grievance.
3) In addition to the resources to address complaints noted above, complaints regarding Substance Use Disorder Treatment may be directed to Wayne Pickerell of the Kansas Department of Aging and Disability Services at Survey, Certification and Credentialing Commission, 115 E. Euclid, McPherson, Kansas 67460 or by calling 620-718-8009.

_____	_____	_____
Client/Guardian Signature	ID Number	Date

NOTICE OF PRIVACY PRACTICES
EFFECTIVE March 21, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. You have the right to a paper copy of this Notice; you may request a copy at any time.

Elizabeth Layton Center (ELC) provides health care services in partnership with physicians and other professionals and organizations. The following individuals follow this Notice of Privacy Practices: All individuals employed by Elizabeth Layton Center also including volunteers and students and any health care professional who examines or treats you at any Elizabeth Layton Center facility

References to "Elizabeth Layton Center (ELC)" and "we" in this notice includes each of these individuals and organizations. You will be asked to provide a written acknowledgement of your receipt of this Notice. We are required by law to make a good-faith effort to provide you with our Notice and obtain such acknowledgement from you. However, your receipt of care and treatment from ELC is not conditioned upon you providing the written acknowledgement.

If you have any questions about this Notice, please contact: **Elizabeth Layton Center, Inc./Privacy Officer**

PO Box 677/ 2537 Eisenhower Road
Ottawa, Kansas 66067-0677
785-242-3780

OR

PO Box 463/25955 W 327th Street
Paola, Kansas 66071-4920
913-557-9096

HOW ELIZABETH LAYTON CENTER MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

ELC may use and disclose your protected health information (PHI) for the following Treatment, Payment and Healthcare (TPO) purposes without your express consent or authorization. We will obtain your written authorization before using or disclosing your PHI for any other purpose. You may revoke such authorization, in writing, at any time to the extent ELC has not relied on it.

Treatment. We may use your PHI to provide you with treatment. We may disclose PHI to providers, students or other personnel involved in your care. We also may disclose PHI to persons outside ELC involved in your treatment, such as other health care providers, family members, and friends.

Unless you tell us otherwise, we may leave messages on your voicemail identifying ELC and asking you to return our call or to remind you of a scheduled appointment.

Payment. We may use and disclose your PHI as necessary to collect payment for services we provide to you and/or provide PHI to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to ensure quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

Business Associates. ELC provides some services through contracts or arrangements with business associates. Business associates are required to appropriately safeguard your information.

Creation of De-identified Health Information. We may use your PHI to create de-identified PHI. This means that all data items that would help identify you are removed or modified.

Uses and Disclosures Required by Law. We will use and/or disclose your PHI when required by law to do so.

Disclosures for Public Health Activities. We may disclose your PHI to a government agency authorized (a) to collect data for the purpose of preventing or controlling disease, injury, or disability; or (b) to receive reports of child or elder abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

Disclosures About Victims of Abuse, Neglect, or Domestic Violence. ELC may disclose your PHI to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Disclosures for Judicial and Administrative Proceedings. Your PHI may be disclosed in response to a court order, subpoena, discovery request, or other lawful process if certain legal requirements are met.

Disclosures for Law Enforcement Purposes. We may disclose your PHI to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

***Disclosures Regarding Victims of a Crime*.** In response to a law enforcement official's request, we may disclose PHI with your approval or in an emergency situation or if you are incapacitated if it appears you may have been the victim of a crime.

***Disclosures to Avert a Serious Threat to Health or Safety*.** We may disclose PHI to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

***Disclosures for Specialized Government Functions*.** We may disclose PHI as required to comply with governmental requirements (e.g.. national security or for protection of government personnel or foreign dignitaries).

***Disclosure for Fundraising*.** We may disclose demographic information and dates of service to an affiliated foundation or a business associate that may contact you to raise funds for ELC. You have a right to opt out of receiving such fundraising communications.

Disclosure for Remunerated Treatment Communications. We may disclose PHI for the purposes of communicating treatment alternatives or health-related products or services when ELC receives payment for PHI in exchange for making the communication. You have a right to opt out of receiving such communications.

OTHER USES AND DISCLOSURES.

We will obtain your written authorization before using or disclosing your information for any other purpose not described in this notice. You may revoke such authorization, in writing, at any time to the extent ELC has not relied on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right to Inspect and Copy. You have the right to inspect and copy PHI maintained by ELC. You must complete a specific form. You also have a right to an electronic copy of your PHI. If you request copies, we may charge a reasonable fee. We may deny you access in some circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

Right To Request Amendment. If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form.

Right to an Accounting of Disclosures and Access Report. You have the right to request a list of disclosures of your PHI we have made, with certain exceptions defined by law. You also may request a report indicating who has accessed your PHI maintained by ELC or its business associates in an electronic designated record set in the last three years. To request an accounting or an access report, you must complete a specific form.

Right to Request Restrictions. You have the right to request a restriction on our uses and disclosures of your PHI for TPO. We must accept certain requests to not disclose PHI to your health plan for TPO if you have paid in full out of your own pocket for the item or service. You must complete a specific form. ELC's Privacy Officer is the only person who has the authority to approve the request.

Right to Request Alternative Methods of Communication. You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form. ELC's Privacy Officer is the only person who has the authority to act on the request. We will not ask you the reason for your request, and we will accommodate reasonable requests.

Breach Notification. We are required to provide you with written notice concerning breach of your PHI. You will receive the notice by first-class mail, unless you agree to another form of notice, or we do not have a current address for you. If you have any concerns regarding unauthorized use or disclosure of your PHI or any breach notification made by ELC, you should contact ELC's Privacy Officer.

HEALTH INFORMATION TECHNOLOGY.

ELC participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of TPO. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. You may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Or you may restrict access to all your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all your information. If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information. If you receive health care services in a state other than Kansas, different rules may apply. Please communicate directly with your out-of-state health care provider regarding those rules.

COMPLAINTS.

If you believe your rights with respect to PHI have been violated, you may file a complaint with ELC or with the Secretary of the Department of Health and Human Services. To file a complaint with ELC, please contact ELCs Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** ELC reserves the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.

Elizabeth Layton Center, Inc. ***Please Answer ALL Questions***
Child Registration Form

Child's Name: _____ ***DOB:*** _____ ***SS#***_____

Guardian Information:

___Mother ___Step Mother ___Foster ___Grandmother ___Lives with ___Has Legal Custody

Name: _____ **DOB:** _____**SS#:** _____

Phone: _____ **Address:** _____

___Father ___Step Father ___Foster ___Grandfather ___ Lives with ___ Has Legal Custody

Name: _____ **DOB:** _____**SS#:** _____

Phone: _____ **Address:** _____

Legal Custody (If not listed above)

Name: _____ **Address:** _____

Relationship: _____ **Phone #:** _____

SSI/SSDI Eligibility:

- ☐ Not Applicable
- ☐ Eligible and Receiving Payments
- ☐ Eligible, but NOT Receiving Payments
- ☐ Potentially Eligible (Case Not Yet Submitted)
- ☐ Determined to be ineligible by Review & Decision
- ☐ Determination decision on Appeal

Most Recent Psychiatric Hospitalization:

- ☐ None/Never
- ☐ State Mental Health Hospital
- ☐ Private Psychiatric Hospital
- ☐ General Hospital Psychiatric Ward
- ☐ Inpatient Substance Abuse (Excluding Detox)
- ☐ Residential Mental Health Treatment

Current Custody:

- ☐ Child in JJA Custody or Supervision
- ☐ Child in DCF Custody & Out of Home Placement
- ☐ Child in DCF Custody & Lives at Home
- ☐ Child under DCF supervision, not DCF custody
- ☐ NO JJA or DCF Involvement

Current Residential Setting:

- ☐ Crisis Resolution/Stabilization Unit
- ☐ Emergency Shelter
- ☐ Foster Home
- ☐ Group Home (Levels III/IV/V)
- ☐ Homeless
- ☐ Independent Living
- ☐ Inpatient Psychiatric Hospital
- ☐ Jail/Detention Center
- ☐ Temporarily Living w/Relative/Family/Friend
- ☐ Permanent (Biological/Adoptive/other)
- ☐ Residential Treatment Level VI
- ☐ Other _____

Gross Household Income: $_____

- ☐ Monthly
- ☐ Yearly

# of Members in Household: _____

Current Grade Level: _____

Name of School Attending: _____

Current Education:

- ☐ Not applicable/Not Listed Below
- ☐ Preschool
- ☐ K- 11 (Last year completed) _____
- ☐ Enrolled in Post-Secondary Education
- ☐ Other: _____

Special Education:

- ☐ Not Applicable
- ☐ Regular Classroom with Special Education
- ☐ Special Education (Type)
- ☐ Alternative Education Placement
- ☐ Home-Based School
- ☐ Other_____

Tobacco/Smoker Status (Age 10 and Older):

Tobacco User: Yes ____ NO ___
Tobacco User Current: Yes___ NO___
Smokeless Tobacco Yes ____ NO
Smoker: Yes___ NO___
Use a Vape Device: Yes___ NO___
Smoking Status:
____Never a Smoker ____Current Every Day
____Former Smoker _____Current Some Days
____Light Smoker _____Heavy Smoker
____Smoker Status Unknown
Information not obtained Reason_____

Court/Legal Information:

Attorney: _____
PO: _____
Court: _____
Court Date: _____
Other Info: _____

Family Physician: _____

Referred to ELC by: _____

Religious Preference: _____

Clinical Intake Questionnaire

Client Name: _____

Please state in your own words the nature of your main concern(s) (i.e., what you are now coming to this center: _____

_____

How long have these concerns existed? _____

On the scale below, please estimate the severity of your concern(s) Circle one:

Not very upsetting ***Mildly upsetting*** ***Upsetting*** ***Severe*** ***Very Severe***

Please explain benefits you hope to derive from coming to this center: _____

_____

Circle any of the following that apply to client:

Health Problems	Take Drugs	Unable to Relax	Secure
Need to Change	Considerate	Overeating	Friendly
Exhausted	No Appetite	Shakiness	Nervous
Feel Panicky	Fearful	Can't Keep a Job	Happy
Work Problems	Running Away	Spouse Difficulties	Attractive
Inferiority	Evil	Shy with People	Suicidal
Bad Home Life	Morally Wrong	Independent	Worthwhile
Hearing Voices	School Problems	Guilty	Depressed
Lonely	Can't Make Friends	Life is Empty	Content
Angry	Aggressive	Poor Concentration	Fatigue
Nightmares	Emotional Problems	Tell Lies	Feel Tense
Immature	Misunderstood	Confident	Suspicious
Drinks too much	Easily Excited	Religious Concerns	Confused
Unattractive	Sleeping Problems	Failure	Unassertive
Money Problems	Dizziness	Parental Problems	Intelligent
Sexual Problems	Headaches	School Problems	
In Conflict	Can't Do Anything Right	Other: _____	

Please check the services that could help you with your present concern(s):

Individual Counseling ___
Group Therapy ___
Family Counseling ___
Social Skills and Communication ___
Substance Abuse Treatment ___
Rape Victim Counseling ___
Medication Management ___
Marital Counseling ___
Relaxation Training ___
Child Play Therapy ___
Understanding Personality Makeup ___
Assertiveness Training ___
Parent Effectiveness Training ___
Other: _____

Please list client's hobbies and recreational interests: _____

_____

Elizabeth Layton Center
Insurance Information/Authorization

Client Name: _____ **Client #** _____

Primary Insurance Coverage:

☐ None (Complete the Household Income Form for a Sliding Fee with proof of residence in Franklin or Miami County)

☐ Medicaid/KanCare (Medical Card) ID #: _____

☐ Other ***(the following fields are required & ELC needs a copy of the card)***

Exact Name of Insurance Company:

_____

Policy ID#: _____

Group #: _____

Coverage Effective Date: _____

Policy Holder's Employer:

_____

*Union/Local name or #*_____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Policy Holder's SS#: _____

Policy Holder's Gender: ☐ Male ☐ Female

Policy Holder's Relationship to the Client::

☐ *Self* ☐ *Parent* ☐ *Spouse*

☐ *Other:* _____

Secondary Insurance Coverage:

☐ None

☐ Medicaid/KanCare (Medical Card) ID #: _____

☐ Other ***(the following fields are required & ELC needs a copy of the card)***

Exact Name of Insurance Company:

_____

Policy ID#: _____

Group #: _____

Coverage Effective Date: _____

Policy Holder's Employer:

_____

*Union/Local name or #*_____

Policy Holder's Name: _____

Policy Holder's D.O.B: _____

Policy Holder's SS#: _____

Policy Holder's Gender: ☐ Male ☐ Female

Policy Holder's Relationship to the Client::

☐ *Self* ☐ *Parent* ☐ *Spouse*

☐ *Other:* _____

☐ **This is a change in insurance that is currently on file:**

Name of Previous Insurance: _____ *Coverage End Date:* _____

I hereby authorize payment directly to the Elizabeth Layton Center, Inc., of insurance benefits payable under the terms of my insurance plan(s) indicated above. In addition, I authorize the release of any medical information necessary to process the insurance claim(s). I also request payment of government benefits, if any, to the Elizabeth Layton Center, Inc.

I understand that if all program requirements are met by the provider and payment is not made by the Insurance Company(ies) listed above, I may be held responsible for the charges. A copy of this authorization shall be considered as effective and valid as the original.

Date: _____ **Authorized Signature:** _____

❑ Copy of Insurance Card
❑ Copy of Driver's License/Photo ID

ELIZABETH LAYTON CENTER
For Hope and Guidance

Sliding Scale Fee Policy

Elizabeth Layton Center (ELC) offers a sliding scale fee to clients who do not have insurance and are residents of Franklin or Miami County. The sliding scale fee is based on a calculation that considers number of household residents and total household income. It is also determined by the type of service provided. Proof of income is required to establish a sliding scale fee for services.

ELC does not offer a sliding fee scale to clients residing outside of Franklin and Miami counties.

If a client has insurance, ELC is required to collect all co-pay amounts required by the insurance company. These co-pay amounts are not negotiable. If the client is unable to pay their co-pay amount in full at the time of service, ELC will work with the client to set up a payment plan.

If a client has insurance that does not include ELC as part of their network, no sliding scale fee will be offered. The client must either pay full fee for all services or find another provider that is within their network.

However, if the **service is not covered** by insurance due to policy exclusions, regardless of network membership status, the client may be eligible for the sliding scale fee. To qualify for the sliding scale fee, the client must show proof that they are residents of Franklin or Miami County **and** provide all necessary documentation of household income. Under this circumstance, payment amount will be based on the same sliding scale fee used for uninsured clients.

Household Income is defined as: The combined, before-tax (gross) money received by all relatives residing in the home who are over the age of 18. This income would include wages and salaries, unemployment insurance, disability, child support, pensions, trust account payments, and any other similar type of income.

A Household Member is defined as: Any person that spends at least 50% of his/her time living in the home and is related to the head of household.

Elizabeth Layton Center
Household Income Worksheet

Client Name: _____ **Phone:**_____
First Middle Last

Client Address:_____ **DOB:**_____

Number of Household Members: _____ (See definition on cover page) **Client's SS#:** _____

Names of Other Household Members: (Please use back of this page if more room is needed)

_____ _____

_____ _____

If you are a Franklin or Miami County resident **and** you do not have health insurance or have lost your health insurance, you are eligible for the sliding fee scale. The information you provide below will be used for that purpose. This information is also needed by the Elizabeth Layton Center to provide required demographic information for the State of Kansas.

Household Income:

☐ Wages ☐ Salary ☐ Self-Employment	$_____	☐ per month	☐ per year
Social Security	$_____	☐ per month	☐ per year
SSI	$_____	☐ per month	☐ per year
Unemployment	$_____	☐ per month	☐ per year
Child Support	$_____	☐ per month	☐ per year
Disability	$_____	☐ per month	☐ per year
☐ Pension ☐ Trust Fund	$_____	☐ per month	☐ per year
Other Income _____ (please define)	$_____	☐ per month	☐ per year

Under penalties of perjury, by executing this document, I certify that I am providing Elizabeth Layton Center with **accurate information** regarding my **gross household income** and **household size**.

_____ _____
Signature of Client or Responsible Party Date

***** IMPORTANT ***** Copies of supporting documentation are required.

Copies of acceptable documentation for **proof of income** include but are not limited to:

- Most recent income tax return
- Most recent paycheck stubs for all family members
- Worker's Compensation/Disability Checks
- Signed statement from employer on letterhead stating wages and total number of hours you work each week.
- SRS Statement verifying SSI income
- Child Support checks
- Unemployment benefit statement

Copies of acceptable documentation for **proof of residency** include but are not limited to:

- Current rent or lease agreement, utility bill or mortgage bill
- Paycheck stub showing a home address
- Exception: Homeless client. Determined on a case by case basis.
- Valid vehicle registration showing in county address
- Signed letter on agency letterhead from criminal justice staff person or similar professional

KanCare

Pre-Screening Questionnaire for Presumptive Eligibility

Applicant Name: _____

Applicant Date of Birth: _____

Applicant Phone Number: _____

Please answer the following questions to determine if potentially eligible for Medicaid.

How many family members are in your home? _____

What is your household's total gross monthly income? (before tax deductions) _____

Are you a Kansas Resident?	Yes	No
Are you a US Citizen or Eligible Non-Citizen?	Yes	No
Are you the primary caretaker for a child under age 19 living in your home?	Yes	No
Are you pregnant?	Yes	No
Have you been diagnosed with breast or cervical cancer?	Yes	No
Were you in Foster Care at the time of your 18th Birthday and between the ages of 18 to 26?	Yes	No

ELIZABETH LAYTON CENTER
For Hope and Guidance

FINANCIAL STATEMENT

CERTIFICATION OF ZERO INCOME

Client Name: _____ **DOB:** _____
(please print)

 # in Household: _____

CLIENT MUST INITIAL OPTION #1 AND EITHER OPTION 2 OR 3. IF CLIENT SELECTS OPTION #2, A BANK STATEMENT MUST BE PROVIDED TO VERIFY THAT CLIENT IS RECEIVING NO REGULAR INCOME (WAGES, DISABILITY OR SOCIAL SECURITY, UNEMPLOYMENT, ETC.)

Please initial the following statements that are true:

_____ 1. My household currently has **no** source of income. This includes wages, Disability payments, social security, trust fund, child support, state cash assistance, unemployment, etc. I agree to promptly notify the Elizabeth Layton Center (ELC) if my household income changes and I am still receiving services.

and

_____ 2. My household has a bank account(s) and I have provided ELC staff with a copy of my bank statement(s) for the past 30 days as required by ELC. *ELC will not retain a copy of the bank statement.*

Bank Statement Verified By (ELC Staff): _____
(After verification, return to client or shred this information)

or

_____ 3. My household does **not** have a bank account.

Under *penalties of perjury*, by executing this form, I certify that I am providing Elizabeth Layton Center with accurate information regarding my current household income.

_____ _____
Signature of Client or Responsible Party Date

ELIZABETH LAYTON CENTER
For Hope and Guidance

Consent for Assessment & Treatment

Client Name: _____

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in a mental health and/or substance use disorder assessment at the Elizabeth Layton Center. The purpose of the assessment is to determine my current mental health and/or substance use disorder needs and to develop treatment recommendations.

Understanding My Treatment. Treatment services are designed to help me, my child, or my family with concerns. Benefits from treatment may include: improvement in daily functioning, improved relationships with others, improved behavior, and/or improved mood. At times, treatment may be emotionally difficult; however, ELC staff will help guide me through this process. The Elizabeth Layton Center does not guarantee the success of any treatment.

My therapist possibly holds a masters degree or doctorate in (psychology, social work, counseling, of marriage and family therapy) but does not have a medical doctor's degree and is not authorized to practice medicine and surgery and is not authorized to prescribe drugs.

The Intake Assessment will consist of an interview, but I may also be asked to participate in psychological testing to more thoroughly evaluate my needs. I may also be asked to see additional professional staff who may participate in my evaluation and treatment.

I understand that my service provider may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing quality services to me. I understand that these discussions will be kept confidential unless I authorize that the information be released or unless allowed or required by law (e.g. in case of an emergency, necessary information may be shared with those providing emergency treatment and/or the individual(s) identified as my emergency contact(s); information regarding harm/risk of harm to self or others; and, child and elder abuse or neglect. Please also see Notice of Privacy Practices: the short version is included in the Intake packet and the long version is available upon request.).

I understand that some treatment recommendations may be addressed during the initial interview. Once the Intake Assessment is complete and a treatment plan has been formulated, I will be given the opportunity to review and discuss with my service provider the results of the evaluation, the nature of my condition, and any treatment, including alternatives to these recommendations.

I understand that this consent is **voluntary** and that I may withdraw my consent to treatment at any time.

Permission is hereby given to the Elizabeth Layton Center, Inc., to provide assessment and treatment to:

(Check One) ☐ self ☐ child ☐ other (specify) _____

Parents and Families. Therapy and psychiatric services are the most successful when both parents are involved in treatment of a child. For divorced or separated families, I understand as the parent consenting for the treatment of my child that I am responsible for notifying my child's other parent. Both parents may have access to the child's record, except in rare circumstances. If I have questions about this process, I will ask my service provider.

I acknowledge having received a copy of the **Clients Rights and Responsibilities**, and a copy of the Elizabeth Layton Center's **Notice of Privacy Practices** (as mandated by HIPAA regulations).

Medications/Laboratory Testing: If medications should be prescribed or medical laboratory tests are required as a part of my treatment, I understand that information about me will be shared with the pharmacy (or indigent program) that I obtain medications from to assist in filling and managing prescriptions for me. I am aware that prescriptions may be relayed to the pharmacy electronically through Allscripts ePrescribe. I also give my consent to release my name and my diagnosis (if necessary) for the purpose of requesting laboratory tests and obtaining results that may be needed as a part of my treatment. I understand that ELC participates in K-TRACS (prescription monitoring program) and KHIE (Kansas Health Information Exchange).

☐ **By checking this box, I agree to the terms of this Consent for Assessment and Treatment.**

☐ **By checking this box, I agree to have my information shared with T-TRACS and KHIE**

ELIZABETH LAYTON CENTER

For Hope and Guidance

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This is an agreement between you, _____ and the Elizabeth Layton Center. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights: and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our receptionist or by contacting our Privacy Officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke if (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

☐ **I acknowledge that I have received a copy of the "Notice of Privacy Practices", including information about the permitted uses of my protected health information for treatment, payment and clinic operations.**

☐ **By checking this box, I agree that I have reviewed the Consent to Use and Disclose Health Information.**

ELIZABETH LAYTON CENTER
For Hope and Guidance

Consent for Use of AI Documentation

Client Name: _____

Client DOB: _____

Guardian Name (if applicable): _____

Date: _____

I understand that, as part of providing quality behavioral health services, the Elizabeth Layton Center may use approved Artificial Intelligence (AI) technology to assist my provider with certain administrative and documentation tasks related to my care. AI is used only as a tool to support my provider and is not a substitute for the professional judgment, experience, or decision-making of my clinician.

The primary purpose of AI is to assist my provider with documentation, organization of clinical information, and other approved functions that allow my provider to spend more time focused on providing care.

I understand that my provider remains responsible for my assessment, diagnosis, treatment recommendations, documentation, and all clinical decisions regarding my care. My provider reviews all AI-assisted documentation before it becomes part of my clinical record.

ELC only uses AI technology that has been approved by the organization and is designed to protect the privacy and security of my Protected Health Information (PHI) in accordance with applicable federal and state privacy laws. My information will not be sold or used for purposes unrelated to my treatment.

I understand that, while AI technology may improve the efficiency and accuracy of documentation, no electronic system is completely without risk. As with any electronic health record or healthcare technology, there is a small risk of unauthorized access despite appropriate security safeguards.

I understand that my participation is voluntary. If I choose not to consent to the use of AI-assisted documentation, my decision will not affect my ability to receive services at the Elizabeth Layton Center. I may also withdraw this consent at any time by notifying my provider.

I have had the opportunity to ask questions regarding the use of AI in my care, and my questions have been answered to my satisfaction.

I acknowledge that I have read and understand the information regarding the use of Artificial Intelligence (AI) in my treatment.

I consent to my provider's use of ELC-approved Artificial Intelligence (AI) technology to assist with documentation and other approved functions related to my care.

Permission is hereby given to the Elizabeth Layton Center, Inc., to provide assessment and treatment to:

(Check One) ☐ self ☐ child ☐ other (specify) _____

ELIZABETH LAYTON CENTER
For Hope and Guidance

Client Name: _____ Client Number: _____

Missed Appointments Policy

Participating in the treatment process is an important part of meeting your service goals. We value the time that you have reserved with us for this process, and ask that you make every effort to keep scheduled appointments. This will help assure our ability to meet the needs of all clients at Elizabeth Layton Center.

Please review and acknowledge our Missed Appointment Policy described below with your signature.

- Please **arrive on time** or slightly early for scheduled appointments.
- **Cancellations** must be made **24 hours in advance**. Please call 785-242-3780 (Franklin County) or 913-557-9096 (Miami County) and let us know your intentions for follow-up with services.
- **Cancellations** made **less than 24 hours prior** to scheduled appointment are a **missed appointment**.
- After **two (2) Missed therapy appointments** in a **rolling 90-day period**, you will **not** be able to schedule an appointment with your therapist, and will be required to complete an alternative scheduling appointment. The alternative scheduling options are:

"Same-day Scheduling"- Call the front desk to see if there are any same day appointments available with your therapy provider and attend that same day appointment. This appointment can be attended via telemedicine or in-person.

"Walk-In Appointment" – Attend a first-come-first-serve walk-in appointment for your therapy provider. This appointment can be attended via telemedicine or in-person. Therapists have a walk-in hour on Tuesdays at 2:00p.

"Engaging In Wellness Group" – Attend the therapy group called "Engaging in Wellness". This group is for adult clients only. Call the front desk for details.

24-hour crisis services will be available as needed for emergent mental health needs.

We will do our best to help you meet the Missed Appointment Policy. With your approval, our staff will attempt to **provide reminder call(s) and/or message(s) and/or email(s) about your scheduled appointments** for therapy and medication management. (Standard Messaging Rates will apply.) Please indicate below your choice in how we contact you with scheduled appointment information:

☐ Please do **NOT** remind me about my scheduled appointments.

Appointment Reminder Authorization:

☐ **YES**, I would like to receive an **Automated Reminder Call** Phone#-_____

☐ **YES**, I would like to receive **Text Message Reminder** Phone#-_____

☐ **YES**, I would like to receive an **Email Reminder** Email-_____

I have read and agree to the Missed Appointment Policy and have stated my contact preferences.

☐ **By checking this box, I am agreeing that I have reviewed the Missed Appointment Policy.**

Elizabeth Layton Center only allows one therapy appointment to be scheduled at a time.

☐ **By checking this box, I am agreeing that I understand this Elizabeth Layton Center Policy.**

ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION - PCP

_____	_____	_____	_____
Printed Name of Client	**Maiden Name** (If Applicable)	**Last 4 digits of SSN**	**DOB**

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency:_____ **Relationship to Client:**:_____

Address:_____ City:_____ State & Zip Code:_____

Telephone:_____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
____ Substance Abuse Attendance, Summary of Assessment & Treatment
____Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents
____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS & AIDS-related conditions
____Other-Specific Information_____

All records specified above may be requested or disclosed unless restrictions are specified here:_____

_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____
Signature of parent, guardian or legal representative | Printed Name of Representative | Specify Relationship | Date

X_____ _____
Signature of Witness Date

□ **I do not have a PCP/** □ **I prefer to not authorize exchange of my PHI with my PCP for the following reason(s):**_____

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

❑ **Elizabeth Layton Center - Franklin County**
Attn: Medical Records
PO Box 677
Ottawa, KS 66067
(785) 242-3780 Office
(785) 242-6397 Fax

❑ **Elizabeth Layton Center - Miami County**
Attn: Medical Records
PO Box 463
Paola, KS 66071
(913) 557-9096 Office
(913) 294-9247 Fax

ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION - Pharmacy

_____	_____	_____	_____
Printed Name of Client	**Maiden Name** (If Applicable)	**Last 4 digits of SSN**	**DOB**

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency: _____ **Relationship to Client:**:_____

Address:_____City:_____ State & Zip Code: _____

Telephone: _____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
____ Substance Abuse Attendance, Summary of Assessment & Treatment
____Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents
____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS & AIDS-related conditions
___Other-Specific Information: Current Medication List

All records specified above may be requested or disclosed unless restrictions are specified here:_____

_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____
Signature of parent, guardian or legal representative | Printed Name of Representative | Specify Relationship | Date

X_____ _____
Signature of Witness Date

□ I do not have a Pharmacy/ □ I prefer to not authorize exchange of my PHI with my Pharmacy for the following reason(s):_____

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

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❑ **Elizabeth Layton Center - Miami County**
Attn: Medical Records
PO Box 463
Paola, KS 66071
(913) 557-9096 Office
(913) 294-9247 Fax

ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION - School

_____	_____	_____	_____
Printed Name of Client	**Maiden Name** (If Applicable)	**Last 4 digits of SSN**	**DOB**

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency:_____ **Relationship to Client:**:_____

Address:_____ City:_____ State & Zip Code:_____

Telephone:_____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
____ Substance Abuse Attendance, Summary of Assessment & Treatment
____Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents
____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS & AIDS-related conditions
____Other-Specific Information_____

All records specified above may be requested or disclosed unless restrictions are specified here:_____

_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____
Signature of parent, guardian or legal representative | Printed Name of Representative | Specify Relationship | Date

X_____ _____
Signature of Witness Date

□ **Child does not attend school/□ parent/guardian prefers to not authorize exchange of PHI with school for the following reason(s):**_____

_____

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

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(913) 294-9247 Fax

ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

_____	_____	_____	_____
Printed Name of Client	**Maiden Name** (If Applicable)	**Last 4 digits of SSN**	**DOB**

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency:_____ **Relationship to Client**:_____

Address:_____ City:_____ State & Zip Code:_____

Telephone:_____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
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____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS AIDS-related conditions
____Other-Specific Information_____

All records specified above may be requested or disclosed unless restrictions are specified here:_____

_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____
Signature of parent, guardian or legal representative | Printed Name of Representative | Specify Relationship | Date

X_____ _____
Signature of Witness Date

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

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