



Promoting choices for healthier lives, stronger families, and safer communities.

Thank you for choosing Wilmington Health Access for Teens (WHAT), a program of Coastal Horizons, for your health care needs. We want you to be **VERY HAPPY** with the care you receive.

To begin services, please check the box(es) below of those you are interested in and complete the attached forms.

Once we have received this paperwork, one of our staff members will contact you to schedule.

- MEDICAL/PRIMARY CARE SERVICES** include health checks, sports physicals, vaccines, acute or chronic illnesses treatment, screenings, and referrals. These services are offered at our Oleander Drive location as well as in our Ashley, Hoggard, Laney and New Hanover High School Wellness Centers.
- MENTAL HEALTH THERAPY SERVICES** include outpatient therapy for treatment of emotional and behavioral concerns including anxiety, depression, trauma, mood instability, attention issues, situational stress, grief, and more. These services are offered at our Oleander Drive location, our four High School Wellness Centers, and many other schools in New Hanover County.
- PSYCHIATRIC SERVICES** include evaluation and medication management for mental health concerns. This service is available once our primary care team reviews your needs and/or an assessment and treatment plan has been completed by one of our mental health therapists. Psychiatric medication evaluation and management is provided at our Oleander Drive location.

We accept Medicaid, NC Health Choice, and many commercial insurances. If you do not qualify for Medicaid, NC Health Choice or commercial insurance, other options for payment are available.

Wilmington Health Access for Teens is committed to empowering children, adolescents, and young adults to be healthy, safe, and successful. Please let us know if you have any questions and thank you for letting us serve as your comprehensive health care provider.

Sincerely,

Your Integrated Healthcare Team



Promoting choices for healthier lives, stronger families, and safer communities

Patient Responsibilities

In addition to your rights as a recipient of services, you can ensure the best outcomes for yourself by assuming the following responsibilities:

- 1) Give accurate information to help us provide you with the best possible care.
- 2) Follow the plans that you have agreed to.
- 3) Understand your health, and participate in developing treatment goals/care plans.
- 4) Tell the provider working with you (doctor, nurse, counselor, etc.) about any changes in your health or emotional state.
- 5) Ask questions when you do not understand your care or what you are expected to do following your visit.
- 6) Invite people who will be helpful and supportive to your treatment planning.
- 7) Be considerate of other patients and family members and respect their need for privacy.
- 8) Keep all scheduled appointments. If unable to keep an appointment, *cancel an appointment at least 24-hours in advance.*
- 9) If you arrive more than 10 minutes late for your appointment, you will be asked to reschedule, or wait for the next open appointment, if one is available.
- 10) Inform staff of any medical condition that may be contagious.
- 11) Take medications as prescribed for you.
- 12) Tell your provider if you are having side effects from your medications.
- 13) Tell your provider if your medications are not helping you feel better.
- 14) Tell your provider if you do not agree with their recommendations.
- 15) Tell your provider when and if you want to end treatment.
- 16) Inform us of any changes to the status of your Medicaid, NC Health Choice or commercial insurance.
- 17) Cooperate with those trying to care for you.
- 18) Seek out additional support services in your community if necessary.
- 19) Be sure you understand and agree with referrals to other providers and/or your discharge plan.

Coastal Horizons Center, Inc.

Client Information Form

Instructions: Print Clearly. Use Black Ink. Draw a **SINGLE LINE** through any mistakes.

LAST Name:

Today's Date:

FIRST Name:

MIDDLE Name:

(MAIDEN) Name:

Date of Birth :

Age:

Gender: M F

SSN:

No SSN

Home phone + area code:

Cell phone + area code:

Work phone + area code:

CHC offers automated voice & text reminders for upcoming individual and/or doctor visits.

(Note: Written Authorization for the Use/Disclosure of Protected Health Information is required and standard text rates apply.)

I would like automated reminders using my primary phone:

(choose only **one**) Home Cell Work

I do **NOT** want automated reminders

Do you have any of the following? (please mark all that apply)

Medicaid? No ** Yes **If Yes, type?

Medicare? No ** Yes **If Yes, type? A only B only A and B

Health Choice? No Yes

Private Health Insurance? No ** Yes Name: _____

(Note: Written Authorization for the Use/Disclosure of Protected Health Information is required to contact third parties for billing, a copy of your card is required and all services may not be covered by your insurance.)

Who referred you to Coastal Horizons Center? (please mark all that apply)

- Self DSS TASC Judge/Court Court Counselor
- Family / Friend Voc Rehab State P.O. Private physician School
- Inpatient Facility VA Federal P.O. Other:

Address:

P.O. Box (if applicable):

City:

Zip:

County:

Mailing Address:

Is **English** your preferred language? ** No Yes **If No, list preferred language:

Race:

- Alaskan Native Multiracial
- American Indian/ Pacific Islander
- Native American White
- Asian Unknown
- Black/ Other: _____
- African American

Ethnicity:

- Cuban
- Mexican American
- Puerto Rican
- None Above**

Marital Status:

- Domestic Partners
- Divorced
- Married
- Never Married
- Separated
- Widowed

FOR FRONT DESK OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

Check-In Staff viewed this page as complete: If Insured, did client sign consents to bill? No Yes

If insured, was a copy of the card obtained? No Yes

Printed verification of Medicaid coverage/no coverage attached to CI packet - No Yes Eligible? No Yes

Time arrived: 1414 Medical Center Dr., Wilmington, NC 28401 910-790-9949

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Coastal Horizons Center, Inc.**Client Information Form**

Page 2 of 3

Instructions: Print Clearly. Use Black Ink. Draw a **SINGLE LINE** through any mistakes**Print your name:****FEMALES ONLY:**Are you currently pregnant? **No** **Unsure** ****** **Yes** _____****If yes, name of Dr. or Office following your care:****Highest education grade completed:** _____ *If less than 12th, do you have your GED?* **No** **Yes**Are you currently enrolled in school? **No** ****** **Yes******If yes, what grade are you currently in?** **Name of the school:**

Employment Status:	Unemployed - looking	Receiving Disability Benefits	Seasonal work
Full-time	Unemployed - not looking	Receiving Unemployment	Home-maker
Part-time	Currently a student	Benefits	Retired

When employed, what is your usual occupation?**What best describes your current living arrangements?**

Alone	With child(ren)	Other relatives	With Parents	Other:
With Spouse	Homeless	Others not related	HARRTS	

Are you a Veteran or prior service member? **No** **Yes**Have you had a past head trauma or Traumatic Brain Injury? **No** **Yes**Are you in the Reserves, active military or Guard? **No** **Yes**

Who served in Active Duty? N/A Self Family Member

How many people live in your household?

What is your **annual household** income?

Who is your Primary Medical Care Provider?

Please mark the number of times you have attended any AA, NA or other self-help mutual support groups focused on recovery from substance abuse and dependence in the last 30 days.

No attendance in past month 4-7 times (about 1x wk) 16-30 times (4x's or more a wk)

1-3 times (less than 1x a wk) 8-15 times (2-3x's wk) Sporadic, frequency unknown

FOR OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

Check-In Staff viewed this page as complete:

Confidential Information protected by Federal Regulations: Re-disclosure prohibited unless permitted by regulations 42 CFR Part 2, & 45 CFR Part 160-164. (rev. Spring 2017)

Coastal Horizons Center, Inc.**Client Information Form**

Page 3 of 3

Instructions: Print Clearly. Use Black Ink. Draw a **SINGLE LINE** through any mistakes**Print your name:****In case of an emergency, who should we contact on your behalf?**

Name:

Relationship of emergency contact:

Number (include area code):

City/State:

Are you your own legal guardian? ** No Yes****If NO, please write the name of your legal guardian:****How is this person related to you?****What is their primary phone number (include area code)?****What is their address (include city, state & zip)?**

What brings you to us today and what services are you looking for?

Do you require any of the following?A court ordered evaluation **No** **Yes** A DWI Assessment? **No** **Yes**A one time assessment? **No** **Yes** Counseling specific to a DWI? **No** **Yes****How many times in the last 30 days have you been arrested?****Legal issues:**Do you have any criminal charges pending? **No** ****** **Yes** ****Court Date:**Do you have any outstanding warrants? **No** ****** **Yes** ****Charge:**Are you on any kind of probation? **No** ****** **Yes** **** Supervised** **** Unsupervised**Is treatment required by your probation officer? **No** ****** **Yes** ****P.O. Name:**Is this treatment required by the courts? **No** ****** **Yes** ****Why:**Are you currently enrolled in TASC? **No** ****** **Yes** ****TASC Staff Name:****Information included on this document is true to the best of my knowledge:****Client Signature:** _____**FOR OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE**

Check-In Staff viewed this page as complete:

Time completed:

COASTAL HORIZONS CENTER, INC Outpatient Mental Health / Substance Abuse Services Assignment of Benefits & Financial Responsibility

I have requested mental health and/or substance abuse treatment services from Coastal Horizons Center, Inc. on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I understand that I will be responsible for any court costs or collection of fees should it become necessary to take action to collect for services rendered. I understand that it is my responsibility to notify Coastal Horizons Center, Inc. of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill or co-pays as determined by Coastal Horizons Center, Inc. and/or my health care insurer if the submitted claims or any part of them, which are denied for payment. I understand by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

I hereby assign all medical, mental health, behavioral health and substance abuse treatment benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Coastal Horizons Center, Inc.

I understand that my health care benefit plan, with limitations, may include coverage by the State of North Carolina and/or North Carolina Medicaid and in such case a Business Associates Agreement with Trillium Health Resources has been contractually established for which I am not required to authorize release/disclosure of protected health information if I reside within Trillium's catchment area.

I understand that an authorization for the release of protected health information is necessary when my health care plan is with private insurance, Medicare, or a local managing entity/managed care organization other than Trillium.

<hr style="border: 1px solid black;"/> Primary Insurance (please print)	<hr style="border: 1px solid black;"/> Policy Number
<hr style="border: 1px solid black;"/> Policy Holder's Name (please print)	<hr style="border: 1px solid black;"/> Relationship to Consumer
<hr style="border: 1px solid black;"/> Secondary Insurance (please print)	<hr style="border: 1px solid black;"/> Policy Number
<hr style="border: 1px solid black;"/> Policy Holder's Name (please print)	<hr style="border: 1px solid black;"/> Relationship to Consumer
<hr style="border: 1px solid black;"/> PATIENT'S Name (please print)	<hr style="border: 1px solid black;"/> DATE

PATIENT'S Signature or RESPONSIBLE Party's Signature (if patient is a minor)
Assignment of Benefits
Rev: 03/12/2016

Coastal Horizons Center, Inc.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Coastal Horizons Center is required by law to maintain the privacy and confidentiality of information about your health, health care, and payment for services related to your health and to provide you with this notice of our legal duties and privacy practices with respect to your protected health information (PHI). Not all situations are described. Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 & 164, the Confidentiality Law 42 C.F.R. Part 2 governing substance abuse treatment records, and state law North Carolina General Statute 122-C that governs mental health, substance abuse, and developmental disability services. Under these laws, Coastal Horizons Center may not say to a person outside of Coastal Horizons Center that you attend(ed) or receive(ed) services, nor may Coastal Horizons Center disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by these laws. We must protect and secure health information that we created or received about your past, present and future health condition, services we deliver or payment for your health care. When we use or disclose this information, we are required to abide by the terms of this notice.

There are other entities (such as a laboratory) with whom we have entered into a Business Associates Agreement and share your health information necessary to the service they provide for us. These Business Associates are obligated by law to appropriately safeguard your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Treatment refers to the provision, coordination, or management of health care and related services by one or more health care providers. Coastal Horizons Center staff involved in your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

For Payment. Payment refers to the activities undertaken by a health care provider to obtain or provide reimbursement for the provision of health care. We may use your information to develop accounts receivable information, bill you, and with your written consent, provide information which may include your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment, to your insurance company or other third party payors.

Health Care Operations. Health Care Operations refers to activities undertaken by Coastal Horizons Center that are regular functions of management and administration activities. We may use your information in monitoring our service quality, staff training and evaluation, medical reviews, contacting you for appointment reminders, provide you with additional information regarding your treatment or other health-related benefits, auditing functions, compliance programs, business planning and accreditation, certification, licensing and credentialing activities.

Public Health Activities. We may use or disclose your protected health information for public health activities to a public health authority authorized by law to collect or receive such information. This would be for the purpose of preventing or controlling disease (such as HIV/AIDS, tuberculosis, syphilis), injury, or disability.

Required by Law. We may use or disclose your protected health information to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. Under the law we must make disclosures of your protected health information to you upon your request. We must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Law Enforcement. We may disclose protected health information to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, or in connection with the reporting of a crime in an emergency. We may disclose your protected health information if you committed a crime on program property or against program personnel.

Public Safety. If you are in a mental health treatment program only, we may disclose your protected health information to avert a serious threat to health or safety, such as physical or mental injury being inflicted on you or someone else.

Child Abuse and Neglect. We may disclose your protected health information to a state or local agency that is authorized by law to receive reports of child abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the initial mandated report.

Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel only.

Health Oversight. We may disclose your protected health information to health oversight agencies for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program and peer review organizations performing utilization and quality control.

Specialized Government Functions. If you are or have been a member of the United States Armed Forces, we may disclose your protected health information as required by military command authorities. We may disclose your protected health information to authorized federal officials for national security and intelligence reasons and to the Department of State for medical suitability determinations.

Persons Involved in Your Care. We may disclose your protected health information to a relative, close personal friend, or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose the minor's protected health information to a parent, guardian or other person responsible for the minor except in limited circumstances.

Research. We may use and share your health information for certain kinds of research. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. In some instances, the law allows us to do some research using your PHI without your approval.

Deceased Patients. We may disclose protected health information regarding deceased patients for determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death by coroners or medical examiners.

Under 42 C.F.R. Part 2, generally, you must sign a written authorization before Coastal Horizons Center can share information for treatment purposes, for health care operations or payment of services. You may revoke any written authorization. The revocation must be in writing. You should understand that we are unable to take back any disclosures we have already made with your authorization and that we are required to retain our records of the treatment and care that we have provided to you. However, the federal law permits Coastal Horizons Center to disclose minimum necessary information without your written permission:

1. For research, audit or evaluations,
2. To report a crime committed on Coastal Horizons Center's premises or against Coastal Horizons Center personnel;
3. To medical personnel in a medical emergency,
4. To appropriate authorities to report suspected child abuse or neglect;
5. As allowed by a court order.
6. Among our workforce, on a need to know basis, to coordinate your care,
7. Among our workforce or within an entity having direct administrative control, on a need to know basis, to conduct our health care operations,
8. To individuals or entities that help Coastal Horizons Center conduct duties in serving you with whom we have a Qualified Service Organization (QSO) or Business Associate (BA) agreement.

Your Rights

This section will briefly mention your privacy rights. If you would like to know more about these rights, please contact the Privacy Officer at (910) 343-0145.

Right to a Copy of Notice: You have a right to receive a paper copy of our Notice at any time. In addition, a copy of this Notice will always be posted in our waiting area and on the Coastal Horizons Center website: <http://www.coastalhorizons.org>.

Right to inspect and request copy of record: In most cases, you have the right to look at or get copies of your records. You must make the request by writing a letter to the Privacy Officer or completing an Access Request Form. You may obtain an Access Request Form from the receptionist. You may submit the completed Access Request Form to your service provider or the receptionist. Coastal Horizons Center will respond to your request within 30 days. In some cases, Coastal Horizons Center may deny your request.

Right to Request Amendment to Record: If you believe that your health information is wrong or some information is missing in your record, you must request, in writing, that Coastal Horizons Center correct or add to the record by writing a letter to the Privacy Officer or completing an Amendment Request Form. You may obtain an Amendment Request Form from the receptionist and you may submit the completed Amendment Request Form to your service provider or the receptionist. Coastal Horizons Center will respond within 60 days of receiving your request. Coastal Horizons Center may deny the request if it is determined that the information is:

- correct and complete, or

- not created by Coastal Horizons Center and/or not part of agency records, or
- not permitted to be disclosed, i.e., information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement that you provide in response, added to your health information. If Coastal Horizons Center approves the request for amendment, we will change the information in your record, inform you, and tell others who need to know about the change.

Right to Request an Accounting of Certain Disclosures: You have the right to request an accounting (a detailed listing) of disclosures that Coastal Horizons Center has made for the previous 6 years (beginning April 14, 2003). If you would like to receive an accounting, you may send a letter to the Privacy Officer or complete an Accounting Request Form. You may obtain an Accounting Request Form from the receptionist.

Request a Restriction of Uses or Disclosures: You have the right to ask that Coastal Horizons Center limit how your health care information is used or disclosed. You may make requests in writing by completing a Restriction Request Form. You may obtain a Restriction Request Form from the receptionist and submit the completed form to the receptionist or your service provider.

Right to Request an Alternate Method of Contact: You have the right to ask that we send your health care or billing information to or contact you at an address or phone number than is different than your home. We must agree to your request as long as it is reasonably easy for us to do so. You must make this request in writing by completing an Alternate Contact Request Form. You may obtain these forms from the receptionist and submit the completed form to the receptionist or your service provider.

Breach Notification: You have the right to be notified in the event that we (or one of our Business Associates) discovers a breach of unsecured protected health information involving your protected health information.

Out of Pocket Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your health information with respect to that item or service not be disclosed to your health plan for purposes of payment or health care operations, and we will honor that request.

Psychotherapy Notes: We will, in accordance to Federal law, obtain your written authorization to release your psychotherapy notes, if any, that are contained in your health records.

How to File a Complaint or Report a Violation: If you believe your privacy rights have been violated or you are dissatisfied with the Coastal Horizons Center privacy policies, procedures or practice, you can file a complaint or grievance in person or in writing with/to any appropriate staff member or the Privacy Officer. You may obtain a complaint form from the receptionist or the Privacy Officer. Individuals may also file a written complaint with the US Department of Health and Human Services (DHHS) Office for Civil Rights (OCR) by mail or e-mail at the address listed below:

Office for Civil Rights
U.S. Dept. of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775
E-mail: OCRmail@hhs.gov

Or by visiting the following website: www.hhs.gov/ocr/filing-with-ocr/

Violations of the Confidentiality Law is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Coastal Horizons Center will not take any action against you or change our treatment of you in any way if you file a complaint.

Coastal Horizons Center may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all health care information that we maintain.

If we make changes to the Notice, we will:

- Post the new Notice in public access areas at our service sites,
- Have copies of the new Notice available upon request,
- Post the new Notice on the agency website at: <http://www.coastalhorizons.org>

For More Information: If you have questions or would like additional information, you may speak to your service provider or the Privacy Officer at (910) 343-0145.

This Notice is effective on April 14, 2003

This Notice revision is effective on March 3, 2017

Coastal Horizons Center, Inc.
615 Shipyard Boulevard
Wilmington, NC 28412

**Privacy Notice Receipt
Form**

- I acknowledge that I have received the Privacy Notice for Coastal Horizons Center.
- I understand that the Privacy Notice discusses how my personal health care information may be used and/or disclosed, my privacy rights with respect to health care information, and how and where I may file a privacy-related complaint.
- I may obtain a copy of the Privacy Notice from:
 - the agency website (<http://www.coastalhorizons.org>), and/or
 - the waiting area receptionist, and/or
 - the agency Privacy Officer (910-343-0145).
- I understand that the terms of this Privacy Notice may be changed in the future, and these changes will be posted:
 - in the waiting area of the agency, and/or
 - on the agency website (<http://www.coastalhorizons.org>), and/or
- I understand that I may request a copy of the new Notice from the receptionist or by writing a letter to the Privacy Officer:

Privacy Officer
Coastal Horizons Center, Inc.
615 Shipyard Boulevard
Wilmington, NC 28412
(Phone: 910-343-0145)

"You May Refuse to Sign This Acknowledgement"

Print Name	Signature	Date
I refuse to sign this acknowledgement	Legal Guardian Signature (if necessary) Date	

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Notice but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation presented us from obtaining acknowledgement
- Other (please specify) _____

Staff Signature	Date	Time of Day	Client Record Number
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Enter Clients Name on "Print Name" Line if Client Refuses and Submit to Medical Records

I, _____, authorize **Coastal Horizons Center, Inc.** to:
(Name of Individual)

Send Authorization For Use And Disclosure Of Protected Health Information Client Contact Guidelines

Choose One: (Staff Contact)

_____ CHC Staff may leave a message on my primary phone with **detailed information**
(Initial)

_____ CHC Staff may leave a message on my primary phone with a **call back number only**
(Initial)

Choose One: (Automated Notices)

_____ Send **both** automated **calls and text message** appointment reminders to the number listed in CHC records (Initial)
and any number forwarded or transferred to that number.

_____ Send **only** automated **text message** appointment reminders to the number listed in CHC records and any
(Initial) number forwarded or transferred to that number.

_____ Send **only** automated **call** appointment reminders to the number listed in CHC records and any number
(Initial) forwarded or transferred to that number.

_____ I am choosing to **NOT** participate with receiving appointment reminders
(Initial)

_____ Send **emails** notifying me of a missed appointment. Email: _____
(Initial)
(Private Email address)

_____ **Mail** written communication to my residence with agency name on return envelope.
(Initial) (Written correspondence may be mailed to your residence without agency name for collection of fees.)

_____ **Other:** _____
(Initial)

The following protected information: **that I am a client of Coastal Horizons Center and appointment date(s) and time(s)** for the purpose of: **appointment scheduling/notification and related services information**

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations. Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that the information to be released may include information regarding alcohol abuse, drug abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric or physical impairments.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it [refer to agency Privacy Notice], and that in any event this consent expires automatically as follows:

Choose One [] This consent shall expire one (1) year from the date executed, **OR**
Client's Initials
[] _____
Client's Initials (Specification of Date, event or Condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Executed this _____ day of _____
Day Month Year

I understand that generally, Coastal Horizons Center, Inc. may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

Signature of Client

Signature of Legal Guardian (when required)

Authorization For Use And Disclosure Of Protected Health Information

I, _____, authorize Coastal Horizons Center, Inc.
(Name of Individual) (Agency or person authorized to use or disclose information)

and N.C. Division of MH/DD/SAS (Consumer Data Warehouse), National Development and Research Institutes, Inc., NC State University Center for Urban Affairs & Community Services (TOPPS), and Trillium Health Resources.

to communicate with each other and to disclose to one another the following protected information: Patient Identifying Information, (Name, Record Number, Date of Birth, Address, Dates of Service, Description of Services, Criminal Justice Status, Income, Involvement with Department of Social Services, Dependent Children Status, and other individual identifying information to comply with Division requirements for IPRS and TOPPS reporting)

(Nature and extent of protected information to be disclosed, as limited as possible)

for the purpose of Outcome/Evaluation/Statistical Reporting/Funding/Reimbursement
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that the information to be released may include information regarding alcohol abuse, drug abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric or physical impairments.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it [refer to agency Privacy Notice], and that in any event this consent expires automatically as follows:

[_____] **This authorization shall expire one (1) year from the date executed, or**
(Initial)

[_____] _____
(Initial) (Specification of Date, event or condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Executed this _____ **day of** _____
Day Month Year

I understand that generally, Coastal Horizons Center, Inc. may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

Signature of Client

Signature of Legal Guardian (when required)

Authorization For Use And Disclosure Of Protected Health Information

I, _____, authorize Coastal Horizons Center, Inc.
(Name of Individual)

to disclose to the individuals or parties listed on my Crisis Prevention Plan and Intervention Plan and/or my Emergency Contact I designated on the Client Information Form the following protected information:

The nature of my emergency or crisis, my participation and status as a client of Coastal Horizons Center, medications/allergies/hypersensitivities I have recorded in my medical record, recommendations for emergency or crisis intervention or management, strategies for crisis/emergency response and stabilization, and my current location in addition to any other information noted below:

(Nature and extent of protected information to be disclosed, as limited as possible)

for the purpose of notification, intervention and management of my condition/crisis/emergency or:

(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that the information to be released may include information regarding alcohol abuse, drug abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric or physical impairments.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it [refer to agency Privacy Notice], and that in any event this consent expires automatically as follows:

 This consent shall expire one (1) year from the date executed, or
Client’s Initials

Client’s Initials (Specification of Date, event or Condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Executed this _____ day of _____
Day Month Year

I understand that generally, Coastal Horizons Center, Inc. may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

Signature of Client

Signature of Legal Guardian (when required)

Authorization For Use And Disclosure Of Protected Health Information

I, _____, authorize Coastal Horizons Center, Inc. and
(Name of Individual) (Agency or person authorized to use or disclose information)

Novant Health _____ to communicate with and disclose to
(Agency or person to whom the requested use or disclosure will be made)

one another the following information:

- 1). Medical and Substance Abuse histories,
- 2). Laboratory & X-ray results, physical examination findings,
- 3). Treatment participation / progress, status in the program, and treatment recommendations,
- 4). Medication and medical orders, Medication Administration Records (MAR),
- 5). Substance Abuse, Medical and Psychiatric diagnoses and/or impressions,
- 6). Discharge Plans, Discharge Summaries,
- 7). Individual identifying health information (ie, date of birth, social security number)

(Nature and extent of protected information to be disclosed, as limited as possible)

for the purpose of Coordination of medical care
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that the information to be released may include information regarding alcohol abuse, drug abuse, HIV infection, AIDS or AIDS related conditions, and psychiatric, psychological or physical impairments.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it [refer to agency Privacy Notice], and that in any event this consent expires automatically as follows:

[] This consent shall expire one (1) year from the date executed, or
Client's Initials
[] _____
Client's Initials (Specification of Date, event or Condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Executed this _____ day of _____
Day Month Year

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Signature of Client Signature of Legal Guardian (when required)

D.O.B. ___/___/___ SSN: _____

Authorization For Use And Disclosure Of Protected Health Information

I, _____, authorize Coastal Horizons Center
(Name of Individual) (Agency or person authorized to use or disclose information)

and Pharmacy: _____ to communicate with and disclose to
(Name of Pharmacy & telephone number)
one another the following protected information:

- 1) Individual identifying health information (i.e., date of birth, social security number)
- 2) Prescription information (date prescribed, prescriber, name of medication(s), refills)

for the purpose of Prescription Information (Medication & Refills)
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations.

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[] This consent shall expire one (1) year from the date executed, or
Client’s Initials

[] _____
Client’s Initials (Specification of Date, event or Condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Executed this _____ day of _____
Day Month Year

I understand that generally, Coastal Horizons Center, Inc. may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

Signature of Client Signature of Legal Guardian (when required.)

D.O.B. ____/____/____ SSN: _____

Authorization For Use And Disclosure Of Protected Health Information

I, _____, authorize Coastal Horizons Center, Inc and
(Name of Individual) (Agency or person authorized to use or disclose information)

_____ to communicate with and disclose to one another
(Agency to whom the requested use or disclosure will be made)

the following protected information: _____

(Nature and extent of protected information to be disclosed, as limited as possible)

for the purpose of _____
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations.

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[] This consent shall expire one (1) year from the date executed, or
Client's Initials
[] _____
Client's Initials (Specification of Date, event or Condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Executed this _____ day of _____
Day Month Year

I understand that generally, Coastal Horizons Center, Inc. may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

Signature of Client Signature of Legal Guardian (when required.)

Authorization For Use And Disclosure Of Protected Health Information

I, _____, **authorize** Coastal Horizons Center, Inc **and**
(Name of Individual) (Agency or person authorized to use or disclose information)

_____ **to communicate with and disclose to one another**
(Agency to whom the requested use or disclosure will be made)

the following protected information: _____

(Nature and extent of protected information to be disclosed, as limited as possible)

for the purpose of _____
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information in NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that the information to be released may include information regarding alcohol abuse, drug abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric or physical impairments.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it [refer to agency Privacy Notice], and that in any event this consent expires automatically as follows:

[] **This consent shall expire one (1) year from the date executed, or**
Client’s Initials
[] _____
Client’s Initials (Specification of Date, event or Condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Executed this _____ **day of** _____
Day Month Year

I understand that generally, Coastal Horizons Center, Inc. may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

Signature of Client

Signature of Legal Guardian (when required.)

CLIENT:

1. Client to read, initial each section, and sign and date form.
2. Parent to initial each section and sign if client is minor.

RECORD NUMBER:

3. CHC Staff will answer questions.

As a client of Coastal Horizons Center, Inc., or as the guardian of such a client, you are assured of certain rights. Among these rights is the right:

1. To dignity, respect, humane care, and freedom from mental, emotional, sexual and physical abuse, neglect and exploitation. You also have the right to receive treatment that is culturally sensitive to you, including sensitivity to social, psychological, physical, and spiritual factors.
2. To treatment, including access to medical care and habilitation, regardless of age, sex, religion, national origin, degree of mental illness, mental retardation, substance abuse, and to:
 - a. Participate in the development of your individualized written service plan developed within 30 days from admission.
 - b. Receive information on potential risks and possible benefits of treatment choices, to refuse any treatment offered, and to terminate treatment - unless you have been court-ordered to attend.
 - c. Not be excessively or unnecessarily medicated, and to have medication ordered and prescribed only by a physician with documentation of such prescriptions in your client record and in accordance with accepted medical standards.
 - d. Confidentiality as explained in the client handbook and in compliance with state and federal laws.
 - e. Not be physically restrained or subjected to search and seizure by any Coastal Horizons Center employee.
3. To live as normally as possible while receiving care and treatment/habilitation.
4. To refuse to be finger printed, audio-taped, video-tape or photographed unless you or your guardian gives consent.
5. To never have corporal punishment at a Coastal Horizons Center facility.
6. To pursue any grievances using the Client Grievance Procedure posted on the public bulletin board and in the OTS Client Handbook, or to contact Disability Rights NC (877) 235-4210 or (919) 856-2195 or www.disabilityrightsnc.org.
7. To consult with legal counsel or private physicians of your own choice at your own expense.
8. To protected privacy of your health information as stated in the Agency Privacy Notice.
9. To timely access to information pertaining to you, including your medical record, to assist you in decision-making.

I have been informed of these rights. _____ (Client/Legal Guardian initials)

A. REQUEST FOR TREATMENT

I do hereby request outpatient treatment for either a substance use and/or mental health disorder from Coastal Horizons Center, Inc. and voluntarily give consent for treatment according to my individualized treatment/case management plan. [GS 122C-57] I understand that I (or those others that I have designated in writing by completing an Authorization For Use and Disclosure of Protected Health Information form) may be contacted by staff on a follow-up basis after I have discontinued my involvement with this agency.

_____ (Client/Legal Guardian initials)

B. EMERGENCY MEDICAL CARE

In the event that I might need emergency medical care while attending Coastal Horizons Center, I give permission for the qualified agency staff to 1) administer emergency care to me & 2) contact 911 for additional medical care. A separate written Authorization for Use and Disclosure of Protected Health Information must be completed to notify family, friends, significant other(s) or primary physician.

_____ (Client/Legal Guardian initials)

C. PROGRAM AUTHORITY / UNDERCOVER AGENTS & INFORMANTS

Coastal Horizons Center, Inc. may not knowingly employ, or enroll as a client, any undercover agent or informant. [42 CFR Part 2, 2.17 a] Therefore, Coastal Horizons Center, Inc. will deny admission or terminate treatment services for any individual known to be an undercover agent or informant.

I have been informed of this notice: _____ (Client/Legal Guardian initials)

D. I have received a copy of the OTS Client Handout, and now understand and agree to abide by the rules & regulations of the program including all of the above.

Signature of Client/Date

Signature of CHC Staff/Date



Record Number: _____

I, [REDACTED] (client name) hereby consent to participate in “*Telemed*” with an approved telemedicine provider from Coastal Horizons Center (CHC).

(client’s initials) [REDACTED] A Coastal Horizons representative has explained, and I understand that *Telemed* may include, but is not limited to, mental health care delivery, psychiatric care, minor or routine primary care needs, diagnosis, consultation, treatment, transfer of medical information, and education using interactive audio, video, or data communications (i.e. phone, cellular phone, internet).

(client’s initials) [REDACTED] A Coastal Horizons representative has explained, and I understand that *Telemed* is the use of electronic information and communication technologies by a treatment provider to deliver services to an individual when he/she is located at a different site than the treatment provider.

(client’s initials) [REDACTED] A Coastal Horizons representative has explained, and I understand that *Telemed* involves the communication of protected health information both orally and/or visually, to healthcare professionals that may or may not be located in my city.

(client’s initials) [REDACTED] Only clients who have mental health, substance use, or primary care needs that can be safely managed to the same standard of care for an in-person visit will be seen through telemedicine. It is my responsibility to follow through with additional instructions such as lab work or going to a higher level of care (e.g. Urgent Care) to ensure that my clinical and/or medical needs are being managed appropriately.

(client’s initials) [REDACTED] I the client will use the telephone and/or Internet service at the originating site to virtually meet with a treatment provider, and the treatment provider will thereby abide by the legal and ethical standards of their state of licensure of North Carolina.

(client’s initials) [REDACTED] A safety plan will be implemented by the treatment provider. My provider and I will both know local crisis services, and routine psychiatric and medical providers. I agree to follow their recommendations as a provision to have on-going *Telemed*. ***Clients should access 911 or the nearest hospital if an emergency occurs.***

(client’s initials) [REDACTED] Treatment provider will ensure that all standards that apply to in-office consultation will be consistent with *Telemed*, including the confidentiality of the client. I understand that a Coastal Horizons Center member of staff may be present to operate equipment or computer software. I can at anytime request this staff to leave, or request that my provider not share sensitive medical information while they are present.

(client’s initials) [REDACTED] It is CHC’s responsibility to provide an appropriate environment to ensure that the transmission is as accurate as possible as well as the confidentiality and integrity of their health information

is verified. Such as ensuring lighting, sound quality, and verifying identification of the presenting client.

(client's initials) [redacted] There is a possibility that, despite the reasonable precautions taken by our organization, transmission of client's health information could be distorted or disrupted by technological failures or accessed by unauthorized individuals.

(client's initials) [redacted] I understand that the laws protecting privacy and the confidentiality of medical information also apply to *Telemed*.

(client's initials) [redacted] I understand that I will be responsible for any copayments or coinsurances that apply to my *Telemed* visit. It is my responsibility to determine if *Telemed* is covered by my insurance carrier.

(client's initials) [redacted] I understand that I have the right to withhold or withdraw my consent to the use of *Telemed* at any time during my treatment without affecting my right to future services. I may revoke my consent orally or in writing at any time by contacting my provider at CHC.

(client's initials) [redacted] As long as this consent is in force (has not been revoked) CHC may provide me with treatment via *Telemed* without the need for me to sign another consent form.

(client's initials) [redacted] I understand that if my treatment provider prescribes a psychotropic medication, it may take up to 72 hours for me to receive via the delivery method agreed with my treatment provider (closest pharmacy if possible or through secured chain-of-custody with CHC staff). Additionally, there may be limited hours that *Telemed* is available. ***In the event of an emergency, I will contact 911 or the nearest hospital for assistance.***

(client's initials) [redacted] I have had the alternatives to a telemedicine consultation explained to me, and, I am choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider

(client's initials) [redacted] I have read and understand this document and will address any concerns or questions with my treatment provider and/or the other CHC treatment team members present for during my treatment sessions.

(client's initials) [redacted] I have been offered a copy of this consent form.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me.

That I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction

Executed this date: [redacted] Client Signature: [redacted]

Guardian/Legal Representative Signature: [redacted]

Relationship to Client: [redacted]

CHC Staff Signature: _____



Wilmington Health Access for Teens (WHAT) of Coastal Horizons Center
Legal Guardian Consent for Treatment of Minors

I _____ (legal guardian) do hereby give Coastal Horizons and its designated personnel my consent for examinations, ordering appropriate lab tests, diagnostic procedures and prescribing medications and treatment for the below named minor.

(Print Full Name of Person to Receive Services)

I understand that North Carolina Law does not require parental consent for minors (persons less than 18 years of age) to receive services for prevention, diagnosis and treatment of sexually transmitted diseases, pregnancy, substance abuse, emotional disturbance and suspected or confirmed sexual abuse or assault.

Legal guardian(s) will be notified regardless of the above if the adolescent minor has an abnormal Pap smear requiring medical/surgical intervention, breast mass, life threatening situations such as suicide threats, failure to seek care for pregnancy and any situation the provider feels is essential to life and death.

Coastal Horizons personnel encourages all minors to share health concerns/findings with their legal guardian(s).

I may revoke this consent at any time except to the extent that services have already been rendered. Otherwise this consent shall continue to remain valid for one year from the date signed.

Printed Name of Legal Guardian _____

Relationship to Minor _____

Signature of Legal Guardian _____

Date _____



Guidelines for Adolescent Preventive Services

Parent/Guardian Questionnaire

Confidential

(Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
 Yes No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your adolescent ever been hospitalized overnight?
 Yes No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
_____	_____
_____	_____

4. Has your adolescent ever had any serious injuries?
 Yes No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
 Yes No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
 If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/hayfever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low iron in blood (anemia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder or kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever or heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis (curved spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe acne	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis (TB)/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis (mono)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (liver disease)	<input type="checkbox"/>	<input type="checkbox"/>	_____				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
 Yes No Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drinking problem/alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endocrine/gland disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>before</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>after</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Seiures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

9. With whom does the adolescent live most of the time? (Check all that apply.)

- Both parents in same household
- Mother
- Father
- Other adult relative
- Stepmother
- Stepfather
- Guardian
- Brother(s)/ages _____
- Sister(s)/ages _____
- Other _____
- Alone

10. In the past year, have there been any changes in your family? (Check all that apply.)

- Marriage
- Separation
- Divorce
- Loss of job
- Move to a new neighborhood
- A new school or college
- Births
- Serious illness
- Deaths
- Other _____

Parental/Guardian Concerns

11. Please review the topics listed below. Check (✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	<input type="checkbox"/>	Guns/weapons	<input type="checkbox"/>
Physical development	<input type="checkbox"/>	School grades/absences/dropout	<input type="checkbox"/>
Weight	<input type="checkbox"/>	Smoking cigarettes/chewing tobacco	<input type="checkbox"/>
Change of appetite	<input type="checkbox"/>	Drug use	<input type="checkbox"/>
Sleep patterns	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>
Diet/nutrition	<input type="checkbox"/>	Dating/parties	<input type="checkbox"/>
Amount of physical activity	<input type="checkbox"/>	Sexual behavior	<input type="checkbox"/>
Emotional development	<input type="checkbox"/>	Unprotected sex	<input type="checkbox"/>
Relationships with parents and family	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Choice of friends	<input type="checkbox"/>	Sexual transmitted diseases (STDs)	<input type="checkbox"/>
Self image or self worth	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>
Excessive moodiness or rebellion	<input type="checkbox"/>	Sexual identity (heterosexual/homosexual/bisexual)	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Work or job	<input type="checkbox"/>
Lying, stealing, or vandalism	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>
Violence/gangs	<input type="checkbox"/>		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?
 What is it? _____

15. Can we share your answers to Question 13 with your teen? Yes No

New Hanover County School Wellness Centers Parent/Guardian Consent Form

Please sign and return this form to your school's main office or the WHAT Wellness Center office.



Dear Parent/Guardian:

All students seeking healthcare at the Wellness Center must have written, parental authorization to participate and receive needed services or as may be required by N.C. law or ethical guidelines for medical professions. If you have any questions, please visit our website (www.whatswhat.org) or call us at (910) 790-9949.

I, _____ (please print), hereby grant permission for my child,

(please print), to participate in the activities and services offered by the Wellness Center in partnership with Wilmington Health Access for Teens (WHAT), a program of Coastal Horizons Center, Inc. Consent is valid for the length of student's enrollment in a New Hanover County High School.

I authorize **ALL** services and activities offered by the Wellness Center. **(circle one)** Yes No
ONLY if you selected **NO**, please circle **Yes** or **No** for each listed service below:

1. Conducting of interviews, tests, and questionnaires for student or project evaluation purposes. Yes No
2. Release of confidential information (financial, public assistance, medical, and all educational records) to qualified professional staff of the Coastal Horizons Wellness Center as needed. Also, from the School Based Health Center/Wellness Center to other qualified professionals for purposes of health care, insurance/Medicaid claims, or to access needed services for my child. Yes No
3. Referrals to other agencies for specific services (e.g. health, public assistance, counseling, psychological testing, etc.). Yes No
4. Participation in services specified in my child's individualized student/family plan, such as counseling, health instruction and cultural enrichment. Yes No
5. Physical health care related activities and services that can include immunizations, telehealth services, well child checks, sports physicals, laboratory services, appropriate health education/promotion, etc. Yes No
 - I understand that I will supply the Wellness Center with a copy of my child's immunization record. If I am not able to supply this record, the Wellness Center will attempt to determine my child's immunization status and the following immunizations will be administered according to the recommendations of the American Academy of Pediatrics: Menactra (for Meningitis), Influenza Vaccine, Hepatitis A and B Series. **NOTE: Tdap (Tetanus, Diphtheria, Pertussis) and MMR (Measles, Mumps, and Rubella) are required for school enrollment.** Yes No
6. Mental/Behavioral health care related activities and services that can include assessment, treatment planning, counseling, referrals and follow up care. Yes No

By signing:

- I understand that there are charges/fees for medical /counseling visits to Wellness Center as in any visit to physician's office/clinic. I also understand that some of these services may not be completely covered under insurance and that I am responsible, within my financial ability, for any unpaid balance.
- I understand that the Wellness Center staff encourages all students to share information with their parents/guardians, and that I will be notified of any life threatening conditions.
- I understand that I may revoke this consent at any time, except to the extent services have already been rendered. Otherwise, this consent shall continue to remain valid from the date signed until my child's enrollment at any New Hanover County High School ends.

Student's Name (please print): _____
(First) (Middle Initial) (Last)

Student's date of birth (month/day/year): _____ Student's Social Security #: _____

Student is enrolled at (Circle one): Ashley Hoggard Laney New Hanover

Sex assigned at Birth: ___M ___F Preferred Pronouns: _____ Age: _____ Grade: _____

Race/Ethnicity:

___ White/Non-Hispanic ___ Black/African American ___ American Indian/Native Alaskan
___ Hispanic ___ Asian ___ Native Hawaiian/Other Pacific Islander

Has your child had Chicken Pox or been vaccinated? YES _____ NO _____
If yes, please provide approximate date of disease _____ or dates of vaccination _____

Parent/Legal Guardian Name: _____ Relationships to Student: _____

Parent/Legal Guardian Name: _____ Relationships to Student: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Date of Birth: _____ Social Security Number: _____

Does your child currently have health insurance (including Medicaid)?
Insurance Company's Name:
Person's name on the insurance card:
Insurance company's telephone #:
Insurance policy #:
Insurance ID #:
Policy Holder's (Parent/Guarantor) Date of Birth: _____ Relationship to Student: _____
Primary care provider or indicate none if you do not have one:
Address of primary care provider:

***Please provide WHAT of Coastal Horizons with a copy (front and back) of your child's insurance or Medicaid card along with this form, or provide WHAT with the card and a copy will be made for you. Thank you!**

Student Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Coastal Horizons Center, Inc., and its school wellness centers do not discriminate against any person on the basis of sex, race, ethnicity, national origin, sexual orientation, gender identity, religion or disability.

Coastal Horizons Center Text Message Informed Consent

First Name (print): _____ **Last Name (print):** _____

DOB: ____ / ____ / _____ **Cell Number: ()** _____ - _____

You may give permission to Coastal Horizons Center to communicate with you by text message (also known as SMS). This form provides information about the risks, conditions for use, how Coastal Horizons Center uses text communications, and to document your informed consent for communicating with you by texting.

RISKS OF USING TEXT MESSAGING: Transmitting information by text messaging has a number of risks to be considered before making a final decision regarding its use. These include but are not limited to:

- a. Text messages can be circulated, forwarded, stored in electronic files and are not encrypted.
- b. Text messages can be immediately broadcast worldwide and received by many intended and unintended recipients.
- c. Senders can easily misaddress a text message.
- d. Text messaging is easier to falsify than handwritten or signed documents.
- e. Backup copies may exist even after the sender and/or recipient have deleted their copies.
- f. Text messages can be intercepted, altered, forwarded, lost in transmission, or used without detection or authorization.
- g. Anyone gaining access to your cell phone may be able to read text messages you sent or received from Coastal Horizons Center.
- h. Text messages can be used as evidence in court.
- i. Text messages you send or receive may incur a charge if your cell phone contract does not cover text messaging or is limited in its number.

CONDITIONS FOR THE USE OF TEXT MESSAGING: Coastal Horizons Center will use reasonable means to protect the security and confidentiality of information sent and received via text messaging; however, due to the risks outlined above, Coastal Horizons Center cannot guarantee the security and confidentiality of text messaging and will not be liable for improper disclosure that is not caused by our own intentional misconduct. All clients/patients wanting to utilize text messaging as a form of communication must provide written consent, which includes agreement with the following conditions:

- a. All text messages to or from a client/patient can be printed out and become a part of the medical record in the same way therapy notes become part of the medical record.
- b. Although our staff will endeavor to read and respond promptly to a text message, we cannot guarantee that any particular text message will be read and responded to within a particular period of time, in the case of emergencies call 911.
- c. If the client's/patient's text message required or invites a response from us and the client/patient has not received a response within a reasonable time period, it is the client's/patient's responsibility to follow up to determine whether the intended recipient received the text message and when a response might be expected.
- d. The client/patient should not use text messaging for communications regarding extra sensitive materials including physical health issues, mental health diagnoses, and/or substance use.
- e. The client/patient is responsible for delegating their desire in writing of any information they do not want sent via text messaging.
- f. The client/patient is responsible for protecting his/her password or other means of access. Coastal Horizons Center will not be liable for breaches of confidentiality caused by the patient or other third party.
- g. You should speak directly with our staff to discuss complex and/or sensitive situations rather than send text messages regarding such situations.
- h. Coastal Horizons Center staff will not forward your identifiable texts to outside parties without your written consent, except as authorized by law.
- i. I understand that I may revoke this consent at any time by advising Coastal Horizons Center in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT: I acknowledge and agree that I have read and fully understand this consent form. I understand the risks mentioned above, and consent to the conditions and instructions outlined on this form. I further waive any and all claims that may arise against Coastal Horizons Center and its employees, resulting from the use of text messaging.

Client Signature _____ Date _____

Signature of Parent/Legal Guardian (if applicable) _____ Date _____