Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_

REGISTRATION CONSENTS

AND PRIVACY ACKNOWLEDGEMENTS

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment, test results or for Diversion Call Backs?

**\_\_\_\_\_Yes \_\_\_\_\_No** if no, is there another number at which we may try to reach you? ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I hereby consent to receive autodialed calls and/or text messages to the phone number provided, and consent to pre-recorded or artificial voice calls, which may include, without limitation, messages to remind me of upcoming appointments and about available healthcare services from or on behalf of Overmountain Recovery. If the telephone number I have provided is changed or re-assigned to another person, I agree to promptly notify Overmountain Recovery of the change. **Yes \_\_\_\_\_No**

3. May we mail to the address you provided information regarding your appointment or test results?

**\_\_\_\_\_Yes \_\_\_\_\_No** if no, is there another address at which we may send you information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you wish us to share health information such as your upcoming appointments, test results, scheduled tests/procedures, and/or medications with a family member or friend?

**\_\_\_\_\_Yes \_\_\_\_\_No** if **yes, please provide name of person(s**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TELEMEDICINE SERVICES**

Telemedicine is the delivery of health care services using electronic interactive audio and visual systems where the health care provider or health care staff and the patient(s) are not in the same physical location. The interactive electronic systems used in telemedicine incorporate network and software security protocols including encryption, to protect the confidentiality of patient information and audio-visual data. These protocols include multiple measures to safeguard the data and protect against intentional or unintentional corruption.

**Patient initial below:**

 \_\_\_\_\_ I understand that while telemedicine can be used to access care, there are potential risks and, as with any medical care, results cannot be guaranteed. These risks can include, among others, unauthorized access, technical problems with transmission, and equipment malfunction that could lead to delays or loss of information. The connection may be discontinued if the access is not adequate.

 \_\_\_\_\_ I understand that in person care will not be withheld if I choose not to participate with the use of telemedicine.

\_\_\_\_\_ I understand that I may terminate the use of telemedicine at any time without any impact to the provision of services.

 \_\_\_\_\_ I consent to use of telemedicine

 \_\_\_\_\_ I do not consent to the use of telemedicine

Mobile Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This telemedicine consent is good for one (1) year from date of signature (for this service)

 **RELEASE OF RECORDS**

I understand a request of my records will not include psychotherapy notes. All records requests will be reviewed by the medical director and a summary of care may be provided if appropriate.

**CONSENT TO PHOTOGRAPH**

I understand that photographs, videotapes, digital or other images may be made or recorded to document my care. I understand that Overmountain Recovery will retain ownership rights to these recordings or other images, but that I will be allowed to view them or obtain copies. I understand that these images will be stored in a secure manner to protect my privacy and that they will be kept for the time period required by law or Overmountain Recovery policy. Images that may identify me may be disclosed for treatment, payment, or health care operations (e.g., for purposes of training medical students), or when required by law.

 REGISTRATION CONSENTS

AND PRIVACY ACKNOWLEDGEMENTS

**CONSENT TO TREAT**

I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant, and nurse practitioner, and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

I agree and consent to the withdrawal and testing of my blood, without further consent by me, in the event that there is an accidental blood borne pathogen exposure to any medical, nursing or other clinical staff, in order to test such blood for the presence of Hepatitis B virus or HBV, Hepatitis C virus or HCV, and Human Immunodeficiency Virus or HIV. I understand and agree that the results of such laboratory testing shall be maintained confidential, except to my treating healthcare providers, any clinical staff so exposed, and as may be allowed by any applicable state or federal statute, regulation or rule of law.

This means that if any medical practice personnel or physicians are exposed to my blood through a needle stick, blood splash or other means while I am being treated, I agree to allow my blood to be drawn and tested for HIV or Hepatitis. The results will be kept confidential except to my physician, any healthcare personnel caring for me, the medical practice personnel exposed or as required or allowed by law. This will be at no charge to me.

If your UDS shows illicit substances, you may be required to confirm that you have a driver until the next random UDS shows compliance with the program. This is at the discretion of the Medical Director. In addition, if you appear to be impaired, you may not be allowed to dose or may be dosed at a lower amount at the discretion of the medical director. If you are allowed to dose, you must provide confirmation that you have a driver. If you do not have a driver, you may not be allowed to dose at any amount.

**BY SIGNING AND DATING THIS ATTACHED SPACE, I ACKNOWLEDGE NOTICE AND RECEIPT OF THE ABOVE INFORMATION, AND RECEIPT OF THE NOTICE OF PRVACY PRACTICES.**

Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Authorized Representative Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Authorized Representative, relationship to Patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

*I understand that my alcohol/drug 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. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR part 2 will continue to protect the confidentiality of the information that identifies me as a patient in an alcohol or other drug program from-re-disclosure. I understand that I have the right not to sign this consent, but by doing so I may be denied admittance to this treatment program. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and in any event that this consent expires. This consent will automatically expire upon discharge from the program.*