Today's Date: _____

CLIENT REGISTRATION

Client's Full Name_____SS#_____Referred By _____

Parent(s)/Legal Guardian_____If a minor/who do they live with _____

Sex_ Age____DOB_____School_____Grade_____EMAIL_____

Client's Address_____City_____State_____ZIP _____

Client's Phone Home_____Work_____Cell _____

Client's Employer_____Address _____

Mother's Address_____City:_____State_____ZIP _____

Mother's Home Phone_____Work_____Cell_____EMAIL_____

Mother's Employer_____Address _____

Father's Address_____City_____State_____ZIP_____

Father's Home Phone_____Work_____Cell_____EMAIL_____

Father's Employer_____Address _____

Emergency Contact_____Relationship_____Phone _____

RESPONSIBLE PARTY INFORMATION

Full Name of Insurer_____SS#_____Relationship to Patient _____

Driver's License No._____DOB_____EMAIL_____

Insurer's Primary Ins. Co._____ID#_____Group _____

Other Ins. Co._____ID#_____Group _____

Other Insurance (Secondary Ins.) Insurer's Name_____DOB _____

Full Name of Spouse_____SS#:_____DOB _____

Spouse's Employer_____Phone_____Ext._____

FINANCIAL AGREEMENT AND RESPONSIBILITY

- I authorize use of this form and release, of information, for all of my insurance submissions.
- I hereby permit a copy of this form, to be used in place of an original, for any release of information needed.
- I authorize direct payment to BreakAway.
- I understand it is my responsibility to pay any deductible, co-pay, drug screens, or any other service not paid by my insurance(s).
- I agree that I am fully responsible for services provided, if there are no insurance benefits or I have no insurance.
- I understand that there will be a $35.00 service charge on all returned checks.
- I understand there is a 24-hour cancellation policy, which requires that I cancel any individual appointment, 24 hours in advance, between the hours of 8am to 6pm Monday through Friday to avoid a charge. The charge of $50.00 will be directly billed to me (responsible party) *not* the insurance company.
- Accounts are subject to a 10% interest charge per year on all unpaid balances, if sent to collection.

Responsible Party's Signature _____ Date _____

CLIENT RIGHTS AND RESPONSIBILITIES

As a client of BreakAway, you are entitled to various rights. It is our goal to ensure that these rights are respected at all times. Below you will find a list of these rights. Please read them and sign at the bottom to acknowledge receipt of this notification.

CLIENT RIGHTS:

1. You have the right to be treated with dignity and respect; as an individual who has personal needs, feelings, preferences and requirements.

2. You have the right to be fully informed of all services available to you through the BreakAway Program and to any charges for those services.

3. You have the right to participate in the development of your treatment plans.

4. You have the right to file grievances in relation to policies and services offered by the facility, without fear or restraint, interference, coercion, discrimination or reprisal.

5. You have the right to confidential treatment of your personal records. Information from these sources will not be released without your prior written consent.

6. Disabled persons have the right to fully access the facility.

7. You have the right to know the qualifications of all staff member providing treatment.

8. You have the right to refuse treatment or stop treatment at any time. I have read and understand these rights.

CLIENT RESPONSIBILITIES:

- Provide accurate information on present complaints, past history and medications
- Share expectation of and satisfaction with the organization
- Ask questions when they do not understand
- Follow care instructions/accept consequences if they are not followed
- Follow the organizations policies and procedures
- Show respect for facility and other client property
- Meet financial commitments

_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature	Parent/Guardian Signature
_____	_____
Staff Signature	Date

To submit a complaint regarding violation of patients' rights please contact: Orange County Patients' Rights Advocacy Services:
405 West 5th Street #477
Santa Ana, CA 92701
Office (714) 834-5647

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

You have the right to refuse to sign this document

I,_____, understand the HIPPA PRIVACY PRACTICE and have the right to a copy of this office's Notice of Privacy Practices. The full HIPPA PRIVACY PRACTICE statement is available upon request.

Client's Printed Name _____

Client's Signature _____

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Date _____

FOR OFFICE USE ONLY

This office attempted to obtain written acknowledgement of receipt of the NOTICE OF PRIVACY PRACTICES, however, we were unable to obtain it because

_____The client refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented this office from obtaining the acknowledgement

Other (see below)

_____

_____

_____

CONSENT FOR TREATMENT

BreakAway Health Corporation is a facility, which provides treatment and counseling for substance abuse, dual diagnosis, eating disorders, self-mutilation, individual or family therapy, Victims of Crime, and other psychological issues. The staff at BreakAway consists of affiliated Psychiatrist and Psychologist, Marriage and Family Therapist (MFT), Certified Drug and Alcohol Counselors (CDAC and CATS), Forensic Counselor, and interns. During the course of treatment, one or more of BreakAway's staff or affiliates may be involved with your treatment plan, either directly or as a consultant.

Non-compliance: If the client chooses not to participate in treatment plan recommendations, the client will not see results from the treatment.

I hereby give BreakAway Health Corporation, its staff or affiliates, permission to provide me or my child with the necessary outpatient treatment.

Participant/Client Signature_____

Parent/Guardian Signature _____

Parent/Guardian Signature _____

Witness/Staff _____

Date _____

FINANCIAL AGREEMENT AND ASSIGNMENT OF PAYMENT

The responsible party agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby obligates himself/herself to pay the account in accordance with the regular rates and terms of BreakAway.

Every effort will be made by BreakAway Health Corporation to verify eligibility and benefit coverage. ***Having insurances does not guarantee a payment of benefits,*** as stated by each individual insurance company. Insurance coverage is not actually known until the first billing is submitted. Authorization for treatment is not a ***guarantee of payment.*** BreakAway is contracted with insurance companies differently than outpatient benefits that therefore may change your benefits you have. If you have no benefit coverage, or benefits become exhausted, BreakAway will make every attempt to work with you in arranging a payment plan. Lack of payment may cause an interruption of services by BreakAway.

It is BreakAway's policy that the responsible party shall be the person who signs the patient registration for admit of herself/himself or their dependent (which is the client). If payment is to be divided or paid by another party that shall not be the responsibility of BreakAway to pursue payment from any other than the admit party. **Private arrangements or sharing of financial responsibility with another party shall not involve BreakAway, in anyway, for arrangements or collection of payments.**

As the Responsible Party, I am aware of the following financial agreements and responsibility. By **initialing** each condition I acknowledge and accept that I am entering a binding financial contract for services I/We will receive at BreakAway Health Corporation.

FINANCIAL AGREEMENT AND RESPONSIBILITY

_____ I authorize use of this form and release, of information, for all of my insurance submissions.
_____ I hereby permit a copy of this form, to be used in place of an original, for any release of information.
_____ I authorize direct payment to BreakAway.
_____ I understand it is my responsibility to pay any deductible, co-pay, drug screens, or any other services not paid by my insurance(s).
_____ I agree that I am fully responsible for services provided, if insurance benefits run out or I have no insurance.
_____ I understand that there will be a $35.00 service charge on all returned checks.
_____ I understand there is a 24-hour cancellation policy, which requires that I cancel any individual appointment, 24 hours in advance, between the hours of 8am to 6pm Monday through Friday to avoid a charge. The charge of $50.00 will be directly billed to me (responsible party) *not* the insurance company.
_____ I understand there will be 10% interest charge per year on unpaid balances that go to collection
_____ I understand that if my financial responsibility should become delinquent, for lack of payment within 30 days, my/our treatment may be suspended until payment arrangements have been made.

Signature _____/_____ Date _____
Print Name

Signature_____/_____Date _____
Print Name

Client's Name _____ Witness _____
Print Name

3151 Airway Ave #D1 Costa Mesa, CA 92626 • Phone (714 957-8229) • Fax (724 957-0244)

Confidentiality Statement

BreakAway Health Corporation is a treatment facility for adolescents and adults. In compliance with federal regulations, we are committed to maintaining their anonymity and confidentiality of any person who seeks treatment in this program.

In signing this document, I agree to not divulge the names, descriptions, any identifying details, or information about any person I see or come into contact with while I am on the premises. This applies before, after, and during business hours.

BreakAway Health Corporation permits immediate family members to attend any events that are associated with our program. Anyone outside the immediate family must gain authorization from clinical staff prior to event attendance. Alumni attending outside of aftercare must also gain authorization from clinical staff prior to attendance.

_____	_____
Print Name	Client Signature
_____	_____
Parent/Guardian Signature	Parent/Guardian Signature
_____	_____
Staff Signature	Date

RECORDS RELEASE AUTHORITY

If client has a Primary Care Physician (PCP), social worker, outside psychiatrist, psychologist, substance abuse counselor, or prior treatment please provide information on this document.

I, _____, hereby authorize
(Client if over 18 or guardian if under 18)

Name: _____
Address: _____
Phone Number: _____
Fax Number: _____
(Former treatment center, therapist, medical doctor, ext.)

To release the following information to: BreakAway Health Corporation
3151 Airway Ave, D1
Costa Mesa, CA 92626
Phone Number: (714) 957-8229
Fax Number: (714) 957-0244

I understand that the recipient may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclose is specifically required or permitted by law.

I further understand that I have a right to receive a copy of this authorization upon my request.

Information Requested:

_____ Medical Examination
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Screening Evaluation
_____ Discharge Summary
_____ Other _____
_____ Medication
_____ Diagnosis
_____ Financial
_____ Summary of Treatment
_____ Progress Note

Dates Covering Authorization _____ to _____

_____
Authorizing Participant Signature Date

_____
Authorizing Program Representative, if applicable Date

For Office Use Only
Employee name: _____ **Date of contact:** _____
Comments: _____
_____
_____

THIRD PARTY FINANCIAL CONSENT

I, _____, hereby give consent for BreakAway staff to initiate correspondence with my third party financial supporter in the event that I am unable to pay for my treatment included but not limited to changes in care, medications, and copays.

Third Party Name: _____

Phone Number: _____

E-Mail: _____

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

CONSENT TO LEAVE MESSAGE

Client Name: _____ Date: _____

Please provide us with the following contact information:

Home Phone: _____

Client Cell Phone: _____

Parent/Guardian Cell Phone: _____ (if client is a minor)

Client Email: _____

Parent/Guardian Email: _____ (if client is a minor)

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction.

I do do not give my permission to leave relevant information related to my treatment on my answering machine, voicemail, and/or via text message.

I do do not give my permission to communicate relevant information related to my treatment via e-mail.

I do do not want relevant information related to my treatment shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information: _____
_____

Client Signature: _____Date: _____

Parent/Guardian Signature: _____Date: _____

Release of Information

I, _____, hereby authorize BreakAway Health Corporation and/or its representative to release general diagnostic information, insurance information, and appropriate program progress updates to the following individual:

Lotus Laboratories
10842 Noel Street, Suite 110
Los Alamitos, CA 90720
Phone: (714) 827-7402

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____