EPIC Behavioral Healthcare

Consent for Treatment, Orientation & Rules and Agreement for Persons Served

EPIC'S MAIN PHONE NUMBER: 904-829-2273

EPIC Central Campus
1400 Old Dixie Highway, Suite A
St. Augustine, FL 32084

EPIC Recovery Center
3574 US 1 South, Suite 111
St. Augustine, FL 32086

EPIC North Campus
3910 Lewis Speedway, Ste 1103
St. Augustine, FL 32084

EPIC Northwest Campus
175 Hampton Point Drive, Suite 2
St. Augustine, FL 32092

Program Orientation

Welcome to EPIC Behavioral Healthcare!

Thank you for choosing EPIC as your behavioral health care provider. Our staff of qualified providers includes specialists in Substance Use Disorders, Substance Use Detoxification, Care Coordination, Family Practice, Youth and Adult Mental Health and Psychiatry. We have the excellence you deserve and the full range of skills you need to ensure your health and wellness!

We provide Substance Use prevention, education and intervention programs, as well as Outpatient Mental Health and Substance Use Treatment at our Central and Northwest Campuses. Our North Campus specializes in Substance Use Treatment with specialized community programs that include Care Coordination and Recovery Peer Support. Our South Campus (the EPIC Recovery Center) also offers inpatient Substance Use Detoxification and Residential Treatment, as well as Recovery Peer Support and Care Coordination.

We would like to tell you about our services, your rights, and responsibilities. As a participant in our program, you have the right to be treated with dignity, sensitivity, courtesy, and respect. You should expect freedom from abuse and/or neglect, humiliation, exploitation of any kind and/or retaliation or barriers to service as a result of reporting an issue that concerns you.

Our staff follows a Code of Ethics and is expected to conduct themselves honestly, ethically and professionally in all business performed on behalf of EPIC and you, the person served. If you

have questions concerning any of the information provided, please feel free to ask a member of our staff.

Participant Responsibilities in all Programs

In order for EPIC to provide the best possible service you must agree to:

- Actively participate in treatment including developing a plan of care you are willing and able to work towards completing;
- Follow rules established by the program and staff;
- Maintain behavior/conduct that assures the safety, comfort and well being of all persons;
- Participate in all program services including compliance with medical protocols, group education programs, counseling services, self-help meetings, and recreational and social activities;
- Pay for services, if applicable, which may be based on a sliding fee schedule in accordance with your agreement with EPIC as determined during your intake appointment or financial assessment;

Participant Rights in all Programs

As a recipient of services from EPIC Behavioral Healthcare, you are ensured certain basic rights. It is important that you know and understand these rights. If needed you may request assistance to gain further understanding. Family members or support persons who are interested in your treatment will also be informed of these rights, should you so choose.

1. Receive treatment and other program services in quantity and quality that is unaffected by your race, sex, sexual orientation, gender identity or expression, creed, color, disability, or national origin.
2. Receive services in an environment free of verbal harassment, bullying, teasing, stalking, domestic violence, racism, sexism, genderism, financial or other exploitation, retaliation, humiliation, neglect or sexual abuse.
3. Receive treatment at a reduced rate based on ability to pay when sufficient space and state resources are available.
4. Meet with your therapist and other staff members, with reasonable notice, to discuss your Care Plan and progress toward treatment goals.
5. Know the benefits and risks of your treatment services.
6. Develop together with your counselor or service team member your plan of care and treatment goals.
7. Know the rules and policies that you will be expected to observe.
8. Have access or referral to needed resources including legal, self-help and advocacy services.
9. Have all records and other information concerning your participation in the program held in strict confidence, in accordance with federal regulations.
10. Understand the limits of confidentiality including mandated reporting, court order, supervised release, medical emergency and criminal behavior.
11. Refuse treatment or to leave the program and to understand possible problems, i.e., medical, legal, or otherwise, that may result from such action.
12. Request review of actions through the grievance process if you believe any of these rights have been violated.

Satisfaction with our Services

Our medical and counseling staff will work closely with you to assist you with the coordination of your services. Please understand that we are constantly striving to ensure that we are providing patients with the best opportunities to achieve their goals through the services we provide directly and the referrals we may recommend. Your feedback about our quality of care and your sense of personal achievement are among the cornerstones by which we measure our success and help guide us in the future to identify things we need to improve. We may from time to time ask you to complete surveys to assist us in this regard, or we may approach you more informally to request your input.

You Have the Right to Make Suggestions and Offer Input to or Services

We want you to be satisfied with the services you receive. If something does not meet your expectations, we encourage you to discuss it promptly with a member of our staff. You may also anonymously make a suggestion using the "Suggestion Form" box in the waiting room(s).

You Have the Right to File a Grievance

We expect all staff and guests to treat each other with mutual respect. If you feel your rights, as listed above, have been violated, we encourage you to discuss it promptly with a member of our staff. If after requesting this assistance, you still feel that you have a legitimate complaint, you can have your concerns reviewed by the supervisory and administrative staff.

All persons receiving services have a right to file a complaint as a formal notice of dissatisfaction with the services of our staff. If such an occasion presents itself, please request a Complaint/Grievance form from any EPIC staff member.

We take the problems of our patients very seriously, so be assured that your complaint/grievance will be heard and receive the prompt attention it deserves.

Confidentiality of Records

Federal law and regulations protect the confidentiality of alcohol and drug use patient records maintained by EPIC Behavioral Healthcare. Generally, EPIC may not say to a person outside the program that a patient attends the program, or disclose any information identifying the patient as an alcohol or drug user unless:

(1) The individual in services (or legal guardian) consents in writing; OR
(2) The disclosure is allowed by a court order; OR
(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for supervision or program evaluation; OR
(4) The individual in services commits or threatens to commit a crime either at the program or against any person who works for the program; OR
(5) In the case of communicable disease reporting; OR
(6) In the case of child abuse or neglect or elderly abuse reporting; OR
(7) In the case of harm or injury to self or others; OR
(8) In the case of third party payers; OR
(9) An investigation relating to the patient's death.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Release of Information (ROI)

Sometimes other individuals or agencies may have information that gives us a more complete picture of you or lend their perceptions to what's happening. Receiving or sharing personal information about you from records with any other party will require your written consent. Should there be a need or potential benefit to sharing information with another party, we will first discuss this matter with you. If your permission is given, we will then assist you with providing written consent.

Assessment Process and Developing a Plan

Each individual entering our program will participate in an assessment process to determine the nature and the extent of the problems you are facing. Your assessment may include a nursing physical screen, a physical examination, lab tests, and a biopsychosocial assessment to help us better understand how we might be of assistance. Your honest answers will help us see how you view the situation and will assist us in working together with you to develop a plan that truly addresses your needs and goals. At any point, if something is not clear to you, please ask about it. This process helps the clinician and the individual served identify the individual's strengths, needs, abilities, and preference for recovery so an individual Care Plan may be developed.

EPIC provides Person-Centered planning for our participants. When developing an individual's Plan, EPIC seeks to include family and professional collaboration during planning, goal setting, and throughout service delivery. Regular opportunities for individuals to discuss progress towards their goals and provide feedback on their program is an important part of our treatment services.

Person-centered planning involves the development of a goals and tasks that enable people to be involved in the planning process, and to take ownership of their own paths to success. Professionals providing services help them figure out where they are, where they want to go and how best to get there. EPIC also encourages peer-to-peer support and networking among persons served. Our goal is for you to meet your goals!

Course of Treatment Services and Activities

During your stay with us, you will be engaging in a variety of services and activities that may include but not be limited to the following:

- **Outpatient Assessment** – A bio-psychosocial history including behavioral health or substance use history, laboratory testing, and other relevant measures.
- **Inpatient Assessment (South Campus only)** – A bio-psychosocial history supplemented by medical and nursing examinations, laboratory testing, and other relevant measures.
- **Care Plan development** – a course of action recommended by EPIC's clinical team with your input to achieve your treatment goals. Activities and target dates will help you on your way.
- **Individual and/or group counseling** – most of our programs include both settings, but your treatment program will be individualized to your needs, abilities, and preferences.
- **Detoxification Inpatient program (South Campus only)** – A medical and supportive counseling routine to assist you in managing toxicity and withdrawing from the physiological and psychological effects of your Substance Use impairment.
- **Residential Inpatient program (South Campus only)** – A medical and supportive counseling routine to assist you in maintaining a sober lifestyle and managing the risks and changes needed following detoxification from your Substance Use impairment.

- **Medication assisted treatment** - The use of authorized drugs to treat your dependence on alcohol or other drugs during the course of clinical treatment.
- **Clinical services** – The use of supportive counseling, clinical counseling, educational groups, self-help meetings, recovery planning, discharge planning, and Care Coordination.
- **Care Coordination services** – The organization of services, resources and supports between two or more participants including the person served and family (with consent) involved in an individual's care to facilitate the effective delivery of health care services.
- **Drug screens** – EPIC utilizes urinalysis drug screens and quick-response breathalyzer tests to inform treatment goals in our treatment programs.
- **Medical services** - Including a medical history, nursing assessment, physical examination, laboratory tests, and review for referral regarding infectious disease testing, and other related diagnostic tests.
- **Psychiatric Evaluation** – An Adult or Child Psychiatrist will perform an evaluation to help determine any mental health or psychiatric diagnoses and any recommended treatment, including therapy and/or medication administration.
- **Psychiatric Medication Management** – An Adult or Child Psychiatrist will monitor a Medication Management program, where the person served will meet and discuss with the Psychiatrist the effects and outcomes of any prescribed medications.

We ask that you participate fully in each recommended activity as it will enhance its meaning to you as an individual. Our goal is ultimately to help you achieve goals that you identify as important.

Care Coordination and Transition Plan / Care Planning

Your primary counselor and/or care coordinator will work with you develop a Care Plan to include the strengths, needs, abilities and preferences that will assist you to achieve your treatment goals. Care plans help to individualize your recovery needs and keep you informed of your progress towards completion of your program. Your Transition Plan will help you continue your success upon discharge from our care. This recovery-oriented plan will include strategies to build a supportive environment for continuing in recovery. This plan can include continued treatment options, living arrangements, employment options and/or continuing education, and additional services for your family. At your discretion, family members can participate in your care planning and will be invited to attend a session one of our campuses.

Transition and Discharge Criteria

Discharge Criteria:

Individuals are successfully discharged when a minimum of 75% of treatment goals have been met and there has been consistent engagement in the treatment process (attendance and involvement in sessions). Examples include but are not limited to:

- Individual has been successfully detoxified or medical risks and is stable.
- Individual has accepted his/her addiction and/or mental health concern and engages in the change process for building and maintaining a recovery plan.
- Individual has been successfully referred for follow-up care with the Care Coordinator.
- Individual builds a recovery support system identifying both internal and external supports and develops an individualized relapse prevention plan.

Other discharge circumstances may include:

- Individual does not remain engaged in working on the agreed upon Care Plan despite revisions and further progress is not likely to occur.

- Individual needs to be transferred to higher level of care or is stable and able to be transferred to a lower level of care.
- The patient decides to no longer participate in the program.

Transition Criteria

An individual can be transferred to another program service when it is determined by the Treatment Team that the patient would benefit from a higher or lower level of care, or a different program. A Transition Plan is developed by the primary counselor with the patient. When it is deemed appropriate for a patient to be discharged from a program, either successfully or not, a discharge summary is completed, sent to appropriate referral source, and placed in the individual's record.

Expectations of Persons Served with Legally Required Appointments, Sanctions or Court Responsibilities

In order for EPIC to provide the referred services you must agree to:

- Maintain an active Release of Information to your referral source in order for EPIC to continuously report your program status and progress to your referral source, regardless of discharge outcome.
- Legally required appointments or enrollments are expected to follow all of EPIC's rules and guidelines. Updates related to your progress will be sent to your legal referral source.
- EPIC will make treatment recommendations only. EPIC will not make any legal recommendations to your referral source. If your behavior results in EPIC terminating your treatment program, you are solely responsible for any actions taken by your legal referral source.

Access to After Hours Care and Emergency Information

If you have an urgent problem during normal business hours, please call the office and ask to speak with a counselor or nurse. Every effort will be made to accommodate you. If you have an urgent problem after normal business hours, please call the South Campus office at (904) 417-7100. In an actual emergency, it is best to call 9-1-1 or go directly to the nearest hospital Emergency Room, where the physician on duty will begin treatment and contact our staff if necessary.

EMERGENCY NUMBERS

Alcoholics Anonymous	904-829-1737
Anonymous Crime Tip Hotline	888-277-TIPS (8477)
Detox (EPIC Recovery Center)	904-417-7100
Domestic Violence Hotline	904-824-1555
Florida Department of Children & Families	904-723-2000
Flagler Hospital Emergency Room (24 hours)	904-819-4300
Flagler Psychiatric Center	904-819-4560
Florida Abuse Hotline	800-96ABUSE (962-2873)
Florida Disability Rights	800-342-0823
Mental Health Resource Center (MHRC)	904-642-9100
Narcotics Anonymous	904-358-6262
National Substance Use Hotline	800-RELAPSE (735-2773)
Poison Control Hotline	800-222-1222
St. Augustine Police/St. Johns County Sheriff's Office	9-1-1
National Suicide Hotline	800-273-TALK (8255)

Voluntary Surrender of Personal Medications

As a participant in an EPIC program, you will be asked to inform your intake counselor of all medications you are currently taking. In the event these medications need to be verified or counted for program participation, you will be required to demonstrate and surrender all medications to the staff for such verification while on campus. Once your visit has completed, your medications will be returned to you to depart the facility.

Weapons and Illicit or Licit Drugs

Weapons and Illicit or Licit drugs (prescription and over-the-counter medications) are not allowed on EPIC property. Any weapons or drugs will be confiscated and/or reported to law enforcement.

Consent to Drug Screening

Drug Screens may be utilized in your program to monitor and enhance the therapeutic process. By entering into EPIC's program, you agree to remain free from all mood-altering drugs, including alcohol and marijuana while enrolled in the program. In addition, you agree to provide urine samples/ breathalyzer analysis upon request while you are enrolled, at the time of the request. Refusal or inconsistency in providing screening sample may effect treatment recommendations.

Consent for Reporting Communicable Disease

If you are found to have evidence of a communicable disease, EPIC is authorized to disclose such information as necessary to the Department of Health as required by Chapters 381 and 384 Florida Statutes, known as "Report of Communicable Diseases to Department".

Policy Concerning Child and Adult Abuse

As a recipient of services at the EPIC Behavioral Healthcare, you are required to be familiar with the Florida Statutes regarding Child and Adult Abuse. It is imperative that you know and understand these Statutes.

Chapter 415, Florida Statutes, protects children and disabled or aged adults from abuse and/or neglect. Section 415 provides for a central abuse registry in the Department of Children and Families services to receive reports of abuse and neglect and defines who must report abuse. The law assigns to DCF all responsibility for receiving, investigating and acting upon such reports.

Abuse is defined as including any non-accidental injury, sexual battery, financial of sexual exploitation or injury to the intellectual or psychological capacity of a person by the parents or other persons responsible for the child's or adult's welfare. Neglect is failure to provide adequate food, clothing, shelter, health care, or needed supervision.

Anyone who suspects child or adult abuse is ethically obligated to report that abuse. The report can be made to the Abuse Registry toll-free line (1-800-96-ABUSE) operated 24 hours per day or to the appropriate local DCF Intake Office.

Seclusion and Restraint

We do not utilize seclusion or restraint in any of our programs. We expect everyone on EPIC property to maintain themselves in a law-abiding manner and respect the rights and property of others. However, should circumstances arise where this is not the case, law enforcement will be contacted.

Education regarding Advanced Directives

Advanced Directives are a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. During the Intake process, the individual will be given education on Advanced Directives. Once educated, participants may be provided with forms on Advanced Directives. While EPIC staff can educate or assist with Advanced Directives, it is the responsibility of the individual to complete and submit Advanced Directives as appropriate.

Program Rules / Standards of Conduct

EPIC serves all members of the community, including families and children. Please help us to keep EPIC a safe, confidential and welcoming environment for ALL persons served as well as visitors and staff. We expect you to obey the following guidelines:

Services Schedule: EPIC is open Monday – Friday 8:30 am – 5:30 pm. Depending on the group schedule for the week, the Administrative office may be open later than 5:30 in order to sign in group participants.

Smoking and other Tobacco Products: Cigarette smoking is not allowed anywhere at the Facility. Tobacco products are not permitted inside the building and may be confiscated.

Automobiles: You may park your vehicle in the EPIC parking lot. Parking in the neighboring business's parking lot is not allowed, and you will be solely responsible for any violations or consequences for trespassing.

Clothing: No inappropriate or revealing clothing. Shirt and shoes must be worn while visiting EPIC facilities. Out of respect for our patients, guests, and staff, please wear appropriate clothing at all times while at EPIC. You may be asked to change, to leave, or to wear an EPIC t-shirt if you dress is considered inappropriate.

Contraband: Use or possession of contraband materials by patients or visitors, such as drugs, alcohol, drug-related paraphernalia, weapons, cigarettes, lighters, vapes or other prohibited items and materials are not acceptable at this facility and may result in an administrative discharge.

Finance: A financial assessment is conducted to identify assistance needs based on sliding scale. Fees for services are fully explained to the patient by an EPIC staff member.

Confidentiality: Federal confidentiality laws prohibit EPIC from releasing identifiable information about individuals serviced without written consent from the individual or legal guardian. With a signed release, we can communicate with your supports or others involved in your care. If you choose not to, we cannot give any information to anyone. Phone messages can be left for an individual if they are urgent in nature.

Food and Beverages: Food and Beverages are not allowed in EPIC waiting rooms or program service areas, including individual and group meetings.

Inappropriate Social Behavior: Violence, destruction of property, threats of harm to other patients or staff and any sexual involvement or sexual contract between patients while on campus is strictly prohibited. Patients and their guests will be held financially responsible for the destruction of property. Violation of this policy is grounds for an immediate discharge.

Media/Electronics: Personal computers, cell phones, iPads, etc. are not permitted during program services. Use of such equipment in the waiting rooms is allowed when it is done with respect to the others in the area. EPIC staff may ask you to discontinue your use if it is inappropriate.

Random Urine Drug Screening and Blood Alcohol Sensor Levels: Random urine drug screening and Alco Sensor testing may be done at intervals on any individual upon staff discretion. Failure to cooperate with testing procedures may result in a refusal to test result and may effect treatment recommendations, including discharge.

Visitors: Any companions, drivers, friends, etc. are not allowed to stay on the property during your program services. As a consideration of all patients' right to confidentiality, your companions are expected to leave the property and return at the time of your completion of each service. EPIC staff will approach any unknown visitors and ask their purpose for being on the property, and request they leave. Refusal may result in a call to law enforcement.

If you choose to not abide by these Program Rules, your continued participation in the program will be reviewed and may result in an administrative discharge.

Reinstatement in EPIC Programs

If you are involuntarily discharged from EPIC's programs for violation of any of EPIC's rules or policies, you have the right to ask for reinstatement. To do so, you will need to contact the Clinical Director or Operations Manager directly by phone or mail. EPIC will take your request into consideration, research your case history including staff input and the reason for discharge. EPIC's Clinical team and/or Management Team will meet to review your eligibility for reinstatement. If you are approved, you will be contacted by the Program Director with any required sanctions or guidelines to your reinstatement.

Facility Orientation and Emergency Procedures

EPIC posts an Emergency Procedures and Evacuation Map at the entrance to each suite. During your intake and orientation, you will be shown the nearest map. If you have any questions regarding the map or its contents, please ask an EPIC staff at any time. The map in each suite will display the locations of the following:

- Emergency Exits
- Storm Shelter areas
- First Aid kits
- Fire suppression equipment.

July 2020

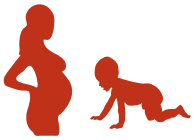
HIV 101

Without treatment, HIV (human immunodeficiency virus) can make a person very sick and even cause death. Learning the basics about HIV can keep you healthy and prevent transmission.

HIV CAN BE TRANSMITTED BY

Sexual Contact

Sharing Needles to Inject Drugs



Mother to Baby During Pregnancy, Birth, or Breastfeeding

HIV IS NOT TRANSMITTED BY

Air or Water

Saliva, Sweat, Tears, or Closed-Mouth Kissing

Insects or Pets

Sharing Toilets, Food, or Drinks

Protect Yourself From HIV

- Get tested at least once or more often if you are at risk.
- Use condoms the right way every time you have anal or vaginal sex.
- Choose activities with little to no risk like oral sex.
- Don't inject drugs, or if you do, don't share needles, syringes, or other drug injection equipment.

- If you are at risk for HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.
- If you think you've been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
- Get tested and treated for other STDs.

Keep Yourself Healthy And Protect Others If You Have HIV

- Find HIV care. It can keep you healthy and help reduce the risk of transmitting HIV to others.
- Take your HIV medicine as prescribed.
- Stay in HIV care.

- Tell your sex or injection partners that you have HIV. Use condoms the right way every time you have sex, and talk to your partners about PrEP.
- Get tested and treated for other STDs.

National HIV/AIDS Hotline: 800-HIV-0440 or 800-448-0440 FL HIV/AIDS Hotline: 800-352-AIDS or 800-352-2435

For more information please visit www.cdc.gov/hiv

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

EPIC Behavioral Healthcare

Informed Consent for Treatment and Participant Agreement

By my signature, I understand and agree to the following:

- ✓ I have read, understand, and have been offered a copy of this Informed Consent for Treatment and Participant Agreement, which includes but is not limited to an explanation of my rights and responsibilities, complaint/grievance procedure, and confidentiality of my patient record.
- ✓ I agree to participate in the intake and assessment process, and to receive services, which could include assessment, stabilization, detoxification, medication treatment, clinical and medical services, drug screens, discharge planning, and Care Coordination services.
- ✓ I agree to follow the Program Rules as discussed.
- ✓ I understand and agree to the exchange of confidential information through Release of Information process
- ✓ I agree to participate in programmatic data collection as needed for this program
- ✓ I was informed that this consent could be revoked by me verbally or in writing, before or during the period in which I receive services, except to the extent that action has been taken on reliance on it.
- ✓ I acknowledge that there have been no guarantees or assurances made to me as the results of services rendered by EPIC, or its employees.
- ✓ I give permission to contact me for the purposes of obtaining follow up information concerning my progress after completing services.

_____

Signature of Person Served Date

_____

Guardian or Legal Custodian Signature, if applicable Date

_____

Staff Signature and Title/Credential Date

☐ Participant Agreement provided to patient.

☐ Signature Page placed in patient record.

EPIC Behavioral Healthcare
Online Therapy Consent Form

Online Therapy and Limitations

I understand that online therapy includes the practice of health care delivery, diagnosis, consultation, treatment, and education using interactive audio and video communication. I understand that discussing my presenting concerns may cause discomfort as difficult issues are addressed and worked through. This is often a common experience of psychotherapy in general and I acknowledge no guarantees have been made to me as to the effect of treatment on my condition. I understand that phone and online sessions have limitations compared to in-person sessions, among those being the lack of "personal" face-to-face interaction, the lack of visual and audio cues in the therapy process, and the fact that most insurance companies will not cover this type of therapy. I understand online therapy is not appropriate if I am experiencing crisis or having suicidal or homicidal thoughts. Should crisis occur, I agree to call 911, go to the nearest emergency room, or contact a crisis hotline (e.g. 800-273-8255).

Procedures for technical difficulties or Internet disruptions

As a client of EPIC Behavioral Healthcare, I understand that online therapy is technical in nature and that problems with the Internet may occur. If something beyond our control disrupts the connectivity of our session I will immediately try to video call the therapist again. If video call is repeatedly unsuccessful for 10 minutes, sessions will be:

1) completed via phone call to the therapist at (904) 829-2273 or
2) refunded based on length of session prior to disruption (e.g. less than 10 minutes the session will be rescheduled at no cost, 15-30 minutes will result in half of the fee being refunded).

Appointment Payment

I agree to pay the agreed upon fee at the time of service through the EPIC Mental Health Outpatient Office in person or by phone. (e.g. through credit card or insurance on file, which will be charged the day of the appointment).

Appointment Cancellations

If cancellation is needed, I understand that notice of at least 24 hours via phone call to the office staff is necessary in order to avoid any associated fees. Cancellations with less than 24 hours notice will be billed at $25 per occurrence.

Missing an appointment without prior notice will be billed at $25 per occurrence. In addition, I understand that the accumulation of 3 late cancellations or missed appointments in any combination will result in discharge from the program.

Termination of Services

During the intake and first few sessions, the therapist will assess if online therapy is of benefit to me and my needs. The therapist will use his/her best judgment to determine if online therapy is the best medium for providing me counseling services. If online therapy is deemed inappropriate, the therapist will provide me with a number of referrals in my area so face-to-face counseling can be pursued.

Confidentiality:

Because online therapy utilizes the Internet for the transmission of personal information I understand the therapist cannot guarantee confidentiality of the personal information I provide via this form of communication. However, any information that I provide to the therapist will subsequently remain confidential and will not be given to a third party unless I give specific permission to release the information, or the therapist is required to do so by law. The issue of confidentiality is further governed by both law and ethics. I understand that the therapist follows the law and professional regulations of

the State of Florida and the counseling treatment provided will be considered to take place in the State of Florida.

By law I hold the privilege of confidentiality and the therapist will not release any information to anyone without my written permission, or a court order. There are some exceptions to my rights under the law. Examples include, but are not limited to, when the therapist has reasonable cause to believe that I am a danger to myself or another person. The therapist is also required by law to report any information about or reasonable suspicion of sexual, physical or emotional abuse of minors or elders to Child Protective Services or Adult Protective Services. I understand that if I have any concerns regarding confidentiality issues, I should speak with my therapist about these and other exceptions to the confidentiality privilege and her responsibility concerning them.

I understand EPIC Behavioral Healthcare has not given consent or release for the recording of this session outside the electronic platform used to deliver the service.

Harm to Self or Others

If there is an emergency during our work together where the therapist is concerned about my personal safety, the possibility of me injuring someone else or about my receiving proper psychiatric care, I understand the therapist will do whatever she can within the limits of the law to prevent me from injuring myself or others and to ensure that I receive the proper medical care. For this purpose, the therapist may also contact law enforcement, hospital or an emergency contact whose name I have provided.

By signing this form I agree with the above.

_____ _____

Signature of Client Date

_____ _____

Signature of Client Date

EPIC BEHAVIORAL HEALTHCARE
CLIENT INFORMATION PACKET

CONSUMER TYPE: ☐ Established ☐ New	**DATE:**	**LOCATION:**
NAME: Last:	First:	Middle:
ALIAS: Last:	First:	Middle:
DATE OF BIRTH:	**SOCIAL SECURITY #:**	**CLIENT ID #:**

CURRENT ADDRESS	**CITY**	**COUNTY**	**STATE**	**ZIP CODE**

HOME PHONE #	**CELL PHONE #**	**WORK PHONE #**	**EMAIL ADDRESS**

SECONDARY ADDRESS	**CITY**	**COUNTY**	**STATE**	**ZIP CODE**

CLIENT RESIDENTIAL STATUS

☐ Independent Alone	☐ Assisted Living Facility	☐ Nursing Home	☐ Children's Residential Treatment
☐ Independent Relatives	☐ Foster Care/Home	☐ Supported Housing	☐ MH Licensed ALF
☐ Independent Non-Relatives	☐ Group Home	☐ Correctional Facility	☐ Other
☐ Dependent Relatives	☐ Homeless	☐ DJJ Facility	☐ Unknown
☐ Dependent Non-Relatives	☐ Hospital	☐ Crisis Residence	

CHILD WELFARE SYSTEM INVOLVEMENT (DCF)		**CURRENT VETERAN STATUS**			**CRIMINAL JUSTICE SYSTEM INVOLVEMENT**		
☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown	☐ No	☐ Yes	☐ Unknown

EMERGENCY CONTACT: **RELATIONSHIP:** ☐ Signed ROI
HOME PHONE NUMBER: **CELL PHONE NUMBER:**
LEGAL GUARDIAN: **RELATIONSHIP:** ☐ Signed ROI
HOME PHONE NUMBER: **CELL PHONE NUMBER:**

☐ Parent ☐ Other Relative ☐ Non-Relative ☐ Emancipated Minor ☐ State or Public Agency ☐ Not Applicable

GENDER	**RACE**	**ETHNICITY**	**MARITAL STATUS**
☐ Male	☐ American Indian	☐ Cuban	☐ Never Married
☐ Female	☐ Asian	☐ Haitian	☐ Married
(Given on ID)	☐ Black	☐ Mexican	☐ Widowed
PREFERRED GENDER	☐ Alaskan Native	☐ Mexican American	☐ Divorced
	☐ Hawaiian/Pacific Islander	☐ Puerto Rican	☐ Separated
	☐ Multi-Racial	☐ Spanish/Latino	☐ Legally Separated
	☐ White	☐ Other Hispanic	☐ Unreported
	☐ Other	☐ None of the Above	☐ Registered Domestic Partner

Primary Language: Secondary Language:
Do you need an interpreter? ☐ No ☐ Yes Type or Language Needed:

EMPLOYMENT STATUS	☐ Full Time	☐ Leave of Absence
☐ Active Military, Overseas	☐ Part Time	☐ Terminated/Unemployed
☐ Active Military, USA	☐ Homemaker	☐ Not Authorized to Work
☐ Disabled	☐ Student	☐ Criminal Inmate
☐ Retired	☐ Unpaid Family Workers	☐ Inmate Other

What is the highest grade level you completed?_____ (Or estimate # years of schooling)

☐ No School ☐ HS Diploma/GED ☐ Some College ☐ AA ☐ BS/BA ☐ Master's ☐ Doctorate ☐ Vocational ☐ Special School

REASON FOR REFERRAL OR PRESENTING PROBLEM:

PLEASE CONTINUE ON THE BACK PAGE

EPIC BEHAVIORAL HEALTHCARE

CLIENT INFORMATION PACKET

FISCAL & INSURANCE INFORMATION

PRIMARY SOURCE OF INCOME (Must be filled in completely)			**TANF STATUS**
☐ Salary	☐ Retirement/Pension/SSI		☐ Temporary Cash Assistance
☐ Wages/TANF	☐ Other		☐ Diversion Family Program
☐ Disability	☐ Unknown	☐ None	☐ Not a TANF Client

ANNUAL INCOME (Must be filled in completely for assistance and sliding scale fee consideration)			
Individual:$	Spouse:$	Food Stamps:$	SSI:$
SSDI:$	TANF:$	Child Support:$	OSS:$
Social Security:$	Other Income:		

TOTAL HOUSEHOLD INCOME	**Total Household Monthly Income**	**Total Household Annual Income**

TOTAL PEOPLE IN HOUSEHOLD	Ages 0-5	Ages 6-12	Ages 13-18	Ages 18 +	**Total # in Household**

POLICY HOLDER (PH) HEALTHCARE INSURANCE INFORMATION		
INSURANCE PROVIDER:		POLICY #:
POLICY HOLDER (PH) NAME:		GROUP #:
RELATIONSHIP TO CLIENT:		PH'S ID #:
PH'S EMPLOYER:		PH'S DOB:
EFFECTIVE DATE:		PH'S SS#:
PH'S HOME PHONE #:		PH'S CELL #:
INSURANCE CO ADDRESS:		
INSURANCE CO PHONE #:		
Annual Deductible:	Co-Pay:	**Hardship Requested? ☐ No ☐ Yes**
Is there another health benefit plan?	☐ No ☐ Yes ☐ Unknown	

SECONDARY POLICY HOLDER (PH) HEALTHCARE INSURANCE INFORMATION	
INSURANCE PROVIDER:	POLICY #:
POLICY HOLDER (PH) NAME:	GROUP #:
RELATIONSHIP TO CLIENT:	PH'S ID #:
PH'S EMPLOYER:	PH'S DOB:
EFFECTIVE DATE:	PH'S SS#:
PH'S HOME PHONE #:	PH'S CELL #:
INSURANCE CO ADDRESS:	
INSURANCE CO PHONE #:	

CLIENT SIGNATURE:	**DATE:**
PARENT/GUARDIAN SIGNATURE:	**DATE:**
WITNESS SIGNATURE:	**DATE:**

PLEASE CONTINUE ON THE NEXT PAGE

EPIC BEHAVIORAL HEALTHCARE
CLIENT INFORMATION PACKET

REFERRAL SOURCE (Check as many as apply)			
☐ Individual (Self Referral)	☐ Other Community Referral	☐ MHSA: DCF/Family Svcs	☐ Physician/Doctor
☐ Substance Use Provider	☐ TASC/Assessment Ctr	☐ CINS (Children in Need Svs)	☐ Law Enforcement
☐ Mental Health Provider	☐ Probation/Parole	☐ Addiction Receiving Fclty	☐ Family Safety Foster Care
☐ Juvenile Justice	☐ DUI/DWI	☐ Outreach Program	☐ Family Safety Protective Svcs
☐ County Public Health Unit	☐ Pretrial	☐ DCF/ADM	☐ None of the Above
☐ School (Educational)	☐ Prison/Jail	☐ Community Hospital	☐ Other:
☐ Employer/EAP	☐ Other Court Order	☐ State Hospital	☐ Other:

Are you providing any information from your referral source(s)?	☐ No	☐ Yes	☐ Unknown

Indicate the number of times you have attended a self help program in the preceding 30 days: **(SOCIAL)**			
☐ None in the past month	☐ 1-3	☐ 4-7	☐ 8-15
☐ 16-30	☐ Some	☐ Unknown	

I would like additional information on services in the community:	☐ No	☐ Yes	☐ Unknown
Are you a registered voter in the United States:	☐ No	☐ Yes	☐ Unknown

MEDICAL HISTORY

PREVIOUS BEHAVIORAL HEALTH DIAGNOSES (Please list any known diagnosis)
Previous Mental Health Diagnosis:
Previous Substance Use Diagnosis:

IDENTIFY ANY KNOWN DISABILITIES OF THE CLIENT		
☐ Developmentally Disabled	☐ Physically Disabled	☐ Non-Ambulatory
☐ Visually Impaired	☐ Hearing Impaired	☐ Severely Impaired English Language
Does mobility impact your activities of daily living? ☐ Yes (Please comment below) ☐ No		
COMMENTS:		

PRIMARY CARE PHYSICIAN
Physician Name/Family Doctor:
Address:
Phone Number:
Date of Last Physical:
Are your immunizations up to date? ☐ No ☐ Yes ☐ Unknown

OTHER MEDICAL EXAMS	
PHYSICIAN	LAST EXAM DATE
Dental:	
Eye/Vision:	
Hearing:	

CURRENT MEDICATIONS			
MEDICATION	DOSAGE	FREQUENCY	TIME
1)			
2)			
3)			
4)			
5)			
6)			
7)			

PLEASE CONTINUE ON THE BACK PAGE

EPIC BEHAVIORAL HEALTHCARE
CLIENT INFORMATION PACKET

RECENT LAB RESULTS		
DATE	LAB TYPE	RESULTS
1)		
2)		
3)		

ALLERGIES		
Do you have any allergies? □ Yes (Please enter below) □ No known food, environmental and/or drug allergies		
ALLERGY	REACTION	SEVERITY
1)		☐ Mild ☐ Moderate ☐ Severe ☐ Fatal
2)		☐ Mild ☐ Moderate ☐ Severe ☐ Fatal
3)		☐ Mild ☐ Moderate ☐ Severe ☐ Fatal
4)		☐ Mild ☐ Moderate ☐ Severe ☐ Fatal
5)		☐ Mild ☐ Moderate ☐ Severe ☐ Fatal

PREGNANCY & POST-PARTUM STATUS		
☐ Not Pregnant or Male	☐ Unknown	
☐ 1st Trimester	☐ 2nd Trimester	☐ 3rd Trimester
Have you given birth in the last 91 days? ☐ No ☐ Yes ☐ Unknown		

MEDICAL PROBLEMS		
Are you/client being treated for ongoing medical problems at this time? If yes, please specify:	☐ No	☐ Yes
Are you/client having any medical problems and not receiving treatment? If yes, please specify:	☐ No	☐ Yes
Have you/client had any significant medical problems in the past? If yes, please specify:	☐ No	☐ Yes
Is there a history of any serious illness(es) or chronic medical problems? If yes, please specify:	☐ No	☐ Yes
Have you/client had any accidents/injuries requiring medical attention? If yes, please specify:	☐ No	☐ Yes
Have you/client had any operations? If yes, please specify:	☐ No	☐ Yes
Do you/client exercise regularly?	☐ No	☐ Yes
Do you have any concerns about your current weight? Height_____ Weight _____	☐ No	☐ Yes
Do you/client drink alcohol or use drugs recreationally or to reduce stress?	☐ No	☐ Yes

TOBACCO USE STATUS (Includes vaping)		
☐ Current Every Day Smoker	☐ Current Some Day Smoker	☐ Former Smoker
☐ Heavy Tobacco Smoker	☐ Light Tobacco Smoker	☐ Never Smoked

PLEASE CONTINUE ON THE NEXT PAGE

EPIC BEHAVIORAL HEALTHCARE
CLIENT INFORMATION PACKET

SUBSTANCE USE PROBLEM **Choose from: Alcohol, Opiates, Barbiturates, Benzodiazepines, Other Sedatives, Stimulants, Hallucinogens-Psychedelics, Solvent/Aerosols/Nitrites/Fuels-Psychedelics, and/or Non-Prescription**
Primary Drug of Choice: (Choose and list from above)
Usual Route of Administration: ☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other
Frequency of Use: ☐ None in Past Month ☐ 1-3 Time in Past Month ☐ 1-2 Times per Week ☐ 3-6 Times per Week ☐ Daily
Age at Primary Substance Usage:
Second Drug of Choice: (Choose and list from above)
Usual Route of Administration: ☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other
Frequency of Use: ☐ None in Past Month ☐ 1-3 Time in Past Month ☐ 1-2 Times per Week ☐ 3-6 Times per Week ☐ Daily
Age at Second Substance Usage:
Third Drug of Choice: (Choose and list from above)
Usual Route of Administration: ☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other
Frequency of Use: □ None in Past Month □ 1-3 Time in Past Month □ 1-2 Times per Week □ 3-6 Times per Week □ Daily
Age at Third Substance Usage:

ARE YOU CURRENTLY ON OPIOID REPLACEMENTS?		
☐ No	☐ Yes	☐ Unknown

INTRAVENOUS DRUG HISTORY (Any current or past history of use)		
☐ No	☐ Yes	☐ Unknown

PLEASE CONTINUE ON THE BACK PAGE

EPIC BEHAVIORAL HEALTHCARE
CLIENT INFORMATION PACKET
LEGAL HISTORY

Do you/client have a legal or school offense history? ☐ Yes **(Please answer questions below)** ☐ No known history

DEPENDENCY OR CRIMINAL STATUS CODES		
CHILDREN		
NON-ADJUDICATED (Outside Legal System)	☐ Custody of Family or Guardian	☐ Other DCF Program
ADJUDICATED (Inside Legal System)	☐ Delinquent - DJJ Facility	☐ Delinquent - Community
☐ Dependent - DCF Custody or Foster Care	☐ Dependent - DCF Protection Home	☐ Terminated/Unemployed
☐ Delinquent & Dependent - In custody	☐ Delinquent & Dependent - Not in Custody	☐ CINS - Not in Custody
INCOMPETENT TO PROCEED	☐ Ages 0-17	☐ Ages 18-20

ADULTS		
NO COURT JURISDICTION	☐ Competent, no charges	☐ Civil Incompetence
CRIMINAL COMPETENT	☐ Incarcerated	☐ Release Pending Hearing
☐ Dependent - DCF Custody or Foster Care	☐ Dependent - DCF Protection Home	☐ Terminated/Unemployed
CRIMINAL INCOMPETENT	☐ Incarcerated	☐ Release Pending Hearing
☐ Involuntary Hospitalization - Direct Commit	☐ Involuntary Hospitalized - Revocation of	☐ Conditionally Released
NOT GUILTY REASON OF INSANITY	☐ Incarcerated	☐ Release Pending Hearing
☐ Involuntary Hospitalization - Direct Commit	☐ Involuntary Hospitalized - Revocation of	☐ Conditionally Released
☐ Incompetent to Proceed		

SCHOOL ATTENDANCE ISSUES			
☐ Suspended	☐ Expelled	☐ Both	☐ No applicable

CRIMINAL (ADULT OR JUVENILE) HISTORY
How many times have you been arrested in the last 30 days?
How many times have you been arrested in the last 24 months?

ARE YOU CURRENTLY INVOLVED IN DRUG COURT?		
☐ No	☐ Yes	☐ Unknown

DAYS IN THE COMMUNITY
How many days, of the last 30 days, have you resided in the community? ☐ All ☐ None ☐ #:_____
(Eliminate days spent in an acute care facility such as a jail or behavioral health unit such as detox, residential or mental health)

epic BEHAVIORAL HEALTHCARE

SNAP Assessment

Strengths, Needs, Abilities, Preferences

Client Name:_____ Date: _____

Client ID: _____ Program: _____

Check all that apply and list what is not shown.

STRENGTHS (What will help you in treatment)		**COMMENTS**
☐	Support from family	
☐	Support from spouse or significant other	
☐	Connection to self-help group (AA, NA, NAMI)	
☐	Connection to a church group of minister	
☐	Supportive friends	
☐	Stable finances or benefits	
☐	Stable housing or shelter	
☐	Stable transportation or access to transportation	
☐	Established primary care (doctor) services	
☐	Distance from unsupportive social network	
☐	Others:	
☐		
☐		
☐		

NEEDS (What you want to learn in treatment)		**COMMENTS**
☐	Education about my diagnosis	
☐	Education about addiction	
☐	Education about the impact of trauma	
☐	Improvement in my communication skills	
☐	Improvement in my interpersonal skills	
☐	Contact with supportive others	
☐	Emotion management skills	
☐	Anger management skills	
☐	Anxiety management skills	
☐	Personal safety and recovery plan	
☐	Parenting skills	
☐	Education about improving my health	
☐	Day to day self-management (structure, goals)	
☐	Others:	
☐		
☐		
☐		

ABILITIES (Your qualities/skills that will help in treatment) **COMMENTS**

☐	I am motivated for treatment	
☐	I have insight in to my mental health or substance use concerns	
☐	I am willing to accept feedback and guidance	
☐	I am willing to take responsibility for my actions	
☐	I am able to ask for help from others	
☐	I am willing to work to grow and change	
☐	I am able to express my concerns and needs	
☐	I have some positive plans and goals for my future	
☐	I have a good relationship with a higher power	
☐	I am capable of offering support to others	
☐	I believe recovery is possible	
☐	I am able to fulfill my treatment obligations	
☐	Others:	
☐		
☐		
☐		

PREFERENCES (What you hope to get out of treatment) **COMMENTS**

☐	I will have a better understanding of my diagnosis	
☐	I will have a better understanding of trauma and its effects	
☐	I will learn the skill to stay mentally stable	
☐	I will learn the skill to stay clean and sober	
☐	I will be able to communicate more effectively	
☐	My interpersonal skills/relationships will improve	
☐	I will be able to manage my emotions	
☐	I will be able to manage my anxiety	
☐	I will be able to manage my anger	
☐	I will be able to resolve grief and loss concerns	
☐	I will develop a positive support network	
☐	My health will improve	
☐	I will have developed a recovery/relapse plan	
☐	I will improve my day to day functioning	
☐	Others:	
☐		
☐		
☐		

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Florida Linking Individuals Needing Care Project

PHQ-9 Screening Tool

Your Name:		Date:	
Home Phone #:		Guardian's Name:	
E-mail Address:		Cell Phone #:	
Referral Source:		Relation to Above:	

Please read each question below very carefully and determine which amount of time most closely describes your current situation.

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all (<1 day)	Several days	More than half the days	Nearly every day
A. Feeling down, depressed, irritable, or hopeless?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
B. Experienced little interest or pleasure in doing things?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
C. Had trouble falling asleep, staying awake or sleeping too much?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
D. Experienced poor appetite, weight loss or overeating?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
E. Feeling tired or having little energy?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
F. Feeling bad about yourself or feeling that you are a failure or that you have let yourself or your family down?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
G. Had trouble concentrating on things like school work, reading or watching tv?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
H. Felt that you were moving or speaking so slowly that others could have noticed? Or so fidgety or restless that you were moving around a lot more than usual?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
I. Thoughts that you would be better off dead or of hurting yourself in some way?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Column Subtotal				

TOTAL

J. How difficult have the items above made it for you to do your school work, take care of things at home, or get along with other people?

☐ Not Difficult at All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

EPIC Behavioral Healthcare

Client HIV/AIDS Risk Assessment

Please Check your response to the following questions:

Have you injected drugs or shared needles/syringes?	☐ Yes	☐ No
Have you had unprotected sex within the last year?	☐ Yes	☐ No
Have you been a sex or needle sharing partner of a person with HIV/AIDS?	☐ Yes	☐ No
Have you traded sex for drugs or money?	☐ Yes	☐ No
Have you had a sexually transmitted disease?	☐ Yes	☐ No
Have you ever had an HIV test?	☐ Yes	☐ No
If Yes, Date: _____ Results: _____		
Are you a hemophiliac or blood transfusion recipient?	☐ Yes	☐ No
Are you a victim of sexual assault?	☐ Yes	☐ No
Have you had sexual relations with:		
An injection drug user?	☐ Yes	☐ No
A person with other/HIV/AIDS risks?	☐ Yes	☐ No
Have you experienced any of the following:		
Unexplained fevers?	☐ Yes	☐ No
Recent unexplained weight changes?	☐ Yes	☐ No

Client was referred to the Public Health Department for follow up Yes ___ No ____

I acknowledge that I have received information regarding the risk factors for HIV / AIDS.

Client Signature: _____ Date:_____

Therapist Signature: _____ Date:_____

epic BEHAVIORAL HEALTHCARE

Tuberculosis (TB) Screening Questionnaire

Please complete the information below:

Date of positive Tuberculosis (TB) test: _____

Date of last chest x-ray for Tuberculosis (TB): _____

Have you ever taken medication for Tuberculosis (TB): YES NO

Name of medication:_____

When did you last take this medication: _____

Have you had any of the following symptoms for 3-4 weeks?

(Unexplained / not related to withdrawal)

- Productive cough YES NO
- Persistent weight loss without dieting YES NO
- Loss of appetite YES NO
- Persistent fever above 100.0 F YES NO
- Night sweats YES NO
- Swollen glands in the neck or elsewhere YES NO
- Coughing up blood (hemoptysis) YES NO
- Shortness of breath YES NO
- Chest pains YES NO
- Fatigue or weakness YES NO
- Frequent or recurring chills YES NO

Then above health statement is true and accurate to the best of my knowledge:

Client Signature: _____ Date:_____

Refer Client to have further screening / medical attention as indicated.

EPIC Behavioral Healthcare
AUTHORIZATION FOR RELEASE OF INFORMATION

***I hereby authorize EPIC Behavioral Healthcare to (please check one*):**
☐ Obtain ☐ Release ☐ Exchange

the following ☐ ***written,*** ☐ ***verbal,*** ☐ ***electronic,*** ☐ ***video,*** ☐ ***audio information*** (check all that apply):

☐ Treatment goals and progress
☐ Psychological evaluation and test results
☐ Information concerning AIDS/ HIV Infection
☐ Physical exam
☐ Educational information
☐ Medical treatment
☐ Social history
☐ Behavioral observation
☐ Alcohol/drug treatment
☐ Psychiatric evaluation and treatment
☐ Other (specify) _____
(In compliance with FS 90.503, 394.459(9), 395.3025(2)(3), 397.501(a) and Federal Regulations 42 CFR, Part 2.)

Information from the records of:

_____ _____
Client Name Client Code/Record #

_____
Address

_____
City, State, Zip

_____
Date of Birth

Contact: _____
Agency Contact Name

To/From (Circle one) _____
Agency Name

_____
Address

_____
City, State, Zip

For information from _____ to _____
Date of Birth Date

For the purpose of (check one): ☐ to assist in the evaluation and treatment of the client.
☐ other (specify_____)

A signed revocation may be submitted at any time, but EPIC Behavioral Healthcare shall not be held liable for any information released prior to its receipt. This release form shall be valid for (check one)

☐ A single disclosure **OR** ☐ A continuing disclosure for **90 days** from signature date below.
☐ A continuing disclosure for **1 year** from signature date below

To Receiving Agency:
PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent or the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.
[In compliance with Federal Regulations 42 CFR, Part 2.]

I acknowledge that I have read this authorization and fully understand its contents.

_____ ____/____/____
Signature of Client Date

_____ ____/____/____
Signature of legal guardian (When applicable) Date

_____
Relationship

_____ ____/____/____
Witness Date

PLEASE RETURN INFORMATION TO:
EPIC Behavioral Healthcare, Attn: _____, 1400 Old Dixie Hwy, St. Augustine, Florida, 32084.
(Name of staff)

EPIC Staff: When requesting information, send original to other Agency. When sending information, keep original in chart.
Originated 7/03

EPIC Behavioral Healthcare
AUTHORIZATION FOR RELEASE OF INFORMATION

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☐ Information concerning AIDS/ HIV Infection
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☐ Psychiatric evaluation and treatment
☐ Other (specify) _____
(In compliance with FS 90.503, 394.459(9), 395.3025(2)(3), 397.501(a) and Federal Regulations 42 CFR, Part 2.)

Information from the records of:

_____ _____
Client Name Client Code/Record #

_____
Address

_____
City, State, Zip

_____
Date of Birth

Contact: _____
Agency Contact Name

To/From (Circle one) _____
Agency Name

_____
Address

_____
City, State, Zip

For information from _____ to _____
Date of Birth Date

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Signature of Client Date

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Signature of legal guardian (When applicable) Date

_____
Relationship

_____ ____/____/____
Witness Date

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(Name of staff)

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Originated 7/03

EPIC Behavioral Healthcare
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the following ☐ ***written,*** ☐ ***verbal,*** ☐ ***electronic,*** ☐ ***video,*** ☐ ***audio information*** (check all that apply):

☐ Treatment goals and progress
☐ Psychological evaluation and test results
☐ Information concerning AIDS/ HIV Infection
☐ Physical exam
☐ Educational information
☐ Medical treatment
☐ Social history
☐ Behavioral observation
☐ Alcohol/drug treatment
☐ Psychiatric evaluation and treatment
☐ Other (specify) _____
(In compliance with FS 90.503, 394.459(9), 395.3025(2)(3), 397.501(a) and Federal Regulations 42 CFR, Part 2.)

Information from the records of:

_____ _____
Client Name Client Code/Record #

_____
Address

_____
City, State, Zip

_____
Date of Birth

Contact: _____
Agency Contact Name

To/From (Circle one) _____
Agency Name

_____
Address

_____
City, State, Zip

For information from _____ to _____
Date of Birth Date

For the purpose of (check one): ☐ to assist in the evaluation and treatment of the client.
☐ other (specify_____)

A signed revocation may be submitted at any time, but EPIC Behavioral Healthcare shall not be held liable for any information released prior to its receipt. This release form shall be valid for (check one)

☐ A single disclosure **OR** ☐ A continuing disclosure for **90 days** from signature date below.
☐ A continuing disclosure for **1 year** from signature date below

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PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent or the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.
[In compliance with Federal Regulations 42 CFR, Part 2.]

I acknowledge that I have read this authorization and fully understand its contents.

_____ ____/____/____
Signature of Client Date

_____ ____/____/____
Signature of legal guardian (When applicable) Date

_____
Relationship

_____ ____/____/____
Witness Date

PLEASE RETURN INFORMATION TO:
EPIC Behavioral Healthcare, Attn: _____, 1400 Old Dixie Hwy, St. Augustine, Florida, 32084.
(Name of staff)

EPIC Staff: When requesting information, send original to other Agency. When sending information, keep original in chart.
Originated 7/03

NATIONAL VOTER REGISTRATION ACT
Preference Form/Application

Client's preference (check the box only in 1. or 2.)

If you do not check any box, it will be considered that you chose not to register or update your voter registration at this time.

1. If you are not registered to vote where you live now, would you like to apply to register to vote today?

☐ Yes ☐ No, I decline.

2. If you are registered to vote where you live now, would you like to update your voter registration record?

☐ Yes ☐ No, I decline.

CLIENT: _____
Name or identification number Date

OFFICIAL USE ONLY (check all that apply)

[Note: Only a client who is eligible can decline or accept an opportunity to register or update a record on his or her behalf]

1. **Client applied for:** New services/assistance
   Renewal of services/assistance Address change
2. **How client applied:** In person By phone
   At home Online/web service
3. **Client:** Submitted registration application.
   Was sent form/application on ___/___/___(date).
   Did not complete application/took form/application.

Preference form must be retained by agency for two years from dated form (DS-DE 77-ENG; rev. 11-2011)

==========Notice of Rights==========

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml or call 1-850-245-6200.

[Authority: National Voter Registration Act (42 U.S.C. 1973gg); sections 97.023, 97.058, and 97.0585, F.S.]

To Register to Vote in Florida, You Must:

- Be a U.S. citizen (a lawful permanent resident cannot register or vote)
- Be at least 18 years old (you may pre-register if you are at least 16 years old although you cannot vote until you are 18 years old)
- Be a Florida resident
- Have had your right to vote restored if you have ever been convicted of a felony
- Have had your right to vote restored if a court has ever declared you to be mentally incapacitated as to your right to vote.

If you do not meet these requirements, you are not eligible to register.

You Can Register to Vote at:

- Any Supervisor of Elections' office
- Any driver's license office or tax collector's office that issues driver's licenses
- Any voter registration agency (that is, any public assistance office, any office that provides services for persons with disabilities, any center for independent living, any armed forces recruitment office or any public library)
- The Division of Elections (Florida Department of State)

You Can Hand-in or Mail a Completed Application to Any of the Locations Listed Above

If mailing, mail with sufficient postage to:

Division of Elections
R.A. Gray Building
500 S. Bronough Street
Tallahassee, Florida 32399-0250

(contact information: 850-245-6200; http://election.dos.state.fl.us)

Your Supervisor of Elections will contact you if your application is incomplete, denied, or a duplicate. Once you are registered, you will receive a voter information card.

**********Turn Page Over for Registration Application**********

Application to Register in Florida

Part 1 - Instructions

To Register in Florida, you must: Be a U.S. citizen, be a Florida resident and at least 18 years old (you may also pre-register if you are 16 or 17 years old but you cannot vote until you are 18).

If you have ever been convicted of a felony or if a court has ever found you to be mentally incapacitated as to your right to vote, your right to vote has to be restored before you can register.

If you do not meet any <u>one</u> of these requirements, you are not eligible to register.

Where to Register: You can register to vote in-person or by mailing or hand-delivering your application to any supervisor of elections' office, any office that issues driver's licenses, any voter registration agency (for example, any public assistance office, assisted living facility, office serving persons with disabilities, public library, or armed forces recruitment office) or the Division of Elections. *If mailing application, be sure to add sufficient postage.*

Deadline to Register: The deadline to register to vote is 29 days before an upcoming election. You can update your registration record at any time, but to change your political party for a primary election, you must make the change by the registration deadline. For a new application, you will be contacted if your application is incomplete, denied or a duplicate of an existing registration. If you receive a voter information card, that means you are registered to vote.

Identification (ID) Requirements: If you are a new applicant, state and federal law require you to provide a current and valid Florida driver's license number (FL DL#) or Florida identification card number (FL ID#). If you have not been issued a FL DL# or FL ID#, you must then provide the last four digits of your Social Security Number (SSN). If you have not been issued any of these ID numbers, check "None" on the application. If you do not provide any number or do not check "None," your registration may be denied. See s.303, HAVA and section 97.053(6), Fla. Stat.

Special ID requirements: If you are registering by mail, have never voted in Florida, <u>and</u> have never been issued one of the ID numbers above, you must include with your application, or at a later time before you vote, one of the following:

- A copy of an ID that shows your name and photo *(acceptable IDs)*--U.S. Passport, debit or credit card, military ID, student ID, retirement center ID, neighborhood association ID, or public assistance ID; **or**
- A copy of an ID that shows your name and current residence address *(acceptable documents)*--utility bill, bank statement, government check, paycheck, or other government document.

You do not have to provide the special ID to register if you are 65 or older, have a temporary or permanent physical disability, are a member of the active uniformed services or merchant marine who is absent from the county for active duty, or a family member thereof, or are currently living outside the U.S. but eligible to vote in Florida.

Political Party Affiliation: Florida is a closed primary election state. That means voters registered with a political party can only vote for that party's candidates in a partisan race on a primary election ballot. However, regardless of the political party with which you registered, you can still vote in the primary election on any issue, any nonpartisan race or any race where the candidate will face no opposition in the general election.

Indicate the political party with which you wish to be registered. If you leave the political party affiliation box blank or write "None," you will be registered without any party affiliation. For a list of political parties registered in Florida, go to the Division of Elections' website under the heading *For the Voters* at: http://election.dos.state.fl.us/

Race/Ethnicity: You are not required to list your race or ethnicity. However, if you choose to do so, please choose only one of the following: American Indian/Alaskan Native, Asian/Pacific Islander, Black (Not Hispanic) Hispanic, Multi-racial, White (Not Hispanic), or Other.

Public Record Notice: This application becomes a public record when filed. However, the following information is not available to the public and is used only for voter registration purposes: your FL DL#, FL ID# and SSN, where you registered to vote, and whether you declined to register or update your voter registration record when asked by a voter registration agency. Your signature can be viewed but not copied. (Section 97.0585, Fla. Stat.)

Criminal Offense: It is a 3rd degree felony to submit false information. Penalties include fines up to $5,000 and/or up to 5 years of prison.

Questions: For more information, contact your local supervisor of elections, or refer to the Division of Elections' website at: http://election.dos.state.fl.us..

Información en español: Sirvase llamar a la oficina del supervisor de elecciones de su condado si le interesa obtener este formulario en español.

Application To Register in Florida

Part 2 - Form (national mail-in application)

Are you a citizen of the United States of America? ☐ Yes ☐ No

Will you be 18 years old on or before election day? ☐ Yes ☐ No

If you checked "No" in response to either of these questions, do not complete form.

(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)

This space for office use only.

1		Last Name	First Name	Middle Name(s)	
2	Home Address		Apt. or Lot #	City/Town	State / Zip Code
3	Address Where You Get Your Mail If Different From Above			City/Town	State / Zip Code
4	Date of Birth (Month Day Year)	5	Telephone Number (optional)	6	ID Number - (See item 6 in the instructions for your state)
7	Choice of Party (see item 7 in the instructions for your State)	8	Race or Ethnic Group (see item 8 in the instructions for your State)		

9 I have reviewed my state's instructions and I swear/affirm that:

- I am a United States citizen
- I meet the eligibility requirements of my state and subscribe to any oath required.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry to the United States.

Please sign full name (or put mark) ➤

Date: Month / Day / Year

If this application is for a **change of name,** what was your name before you changed it?

A		Last Name	First Name	Middle Name(s)

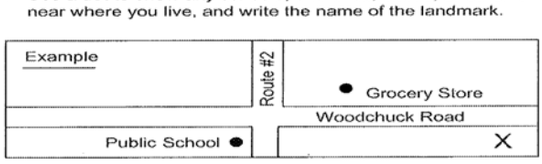
If you were **registered before but this is the first time you are registering from the address in Box 2**, what was your address where you were registered before?

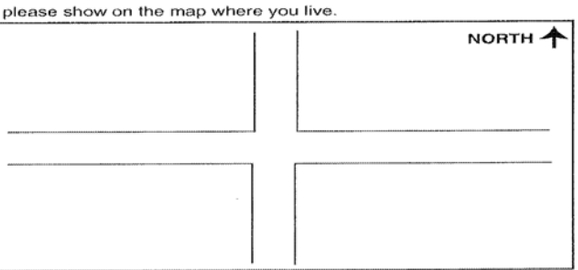
B	Street (or route and box number)	Apt. or Lot #	City/Town/County	State	Zip Code

If you live in a rural area but do not have a street number, or if you have no address, please show on the map where you live.

C

- Write in the names of the crossroads (or streets) nearest to where you live.
- Draw an **X** to show where you live.
- Use a dot to show any schools, churches, stores, or other landmarks near where you live, and write the name of the landmark.





If the applicant is unable to sign, who helped the applicant fill out this application? Give name, address and phone number (phone number optional).

D