



# Unity•Healing•Center

448 Sequoyah Trail Drive

P.O. Box C-201

Cherokee, North Carolina 28719

Phone: (828) 497-3958

Fax: (828) 497-6826



## UNITY MISSION STATEMENT

**Unity is Dedicated to Breaking the Cycle of Addiction and Restoring  
Hope and Wellness to Native American Youth,  
Their Families and Communities!**

# UNITY HEALING CENTER

## ADMISSIONS PROCESS

*Dear Referring Agent,*

*Thank you for choosing Unity Healing Center to provide care for your client. Enclosed you will find the admissions packet and information you will need to ensure a smooth and timely admission for your client.*

*Please note the checklist included on page three. It will guide you in completion of the packet. **To get started in the admissions process Unity requires completion of the pages 4-8.** This information must be completed by a mental health or substance abuse professional and include a diagnosis. Please fax or mail the completed pages as soon as possible.*

*When we receive the information your client will be placed on our waiting list. The admissions team meets weekly and a representative will contact you as soon as possible after the review to give a bed date and to request more information if needed.*

*After you have been informed that a bed date is available we ask that you complete the remaining information in the packet and forward it as soon as possible. **We request that all remaining information be submitted at least a week prior to the client's bed date.** If you have any questions or need more information please do not hesitate to call or email us. We are eager to serve your clients and look forward to working with you.*

*Sincerely,*

*Unity Healing Center Admissions Team*

Savannah Wilnoty: Admissions Coordinator

Ext. 204

[savannah.wilnoty@ihs.gov](mailto:savannah.wilnoty@ihs.gov)

Rebecca Hillane Lambert: Acting Director

Ext. 202

[rebecca.lambert@ihs.gov](mailto:rebecca.lambert@ihs.gov)

Tracey Grant: Clinical Supervisor

Ext. 209

[tracey.grant@ihs.gov](mailto:tracey.grant@ihs.gov)

**Unity Healing Center  
Intake Packet Checklist**

Check-list for Referent to Insure a Complete Packet

<b>1. Client Identifying Information</b>	
<b>2. Client Clinical Information</b>	
<b>3. History &amp; Physical Exam</b> must be performed by a licensed physician (physician's assistant or nurse practitioner as State Law allows) <i>within one month prior to admission</i> . A comprehensive Physical Exam Form may be substituted.	
<b>4. Discharge Summaries and Psych Evaluations</b>	
<b>5. Copies of the following from the client's physician or clinic:</b> <ul style="list-style-type: none"> <li>• Immunization Record (up to date)</li> <li>• Labs (any recent labs)</li> <li>• PPD (Tuberculosis Skin Test within the past year)</li> <li>• Face Sheet from client's I.H.S. Health Facility/Clinic.</li> </ul>	
<b>6. Copies of the following so that the client can be medically treated as needed:</b> <ul style="list-style-type: none"> <li>• Social Security Card</li> <li>• Birth Certificate</li> <li>• Proof of Enrollment in a Federally Recognized Tribe</li> <li>• Photo ID</li> <li>• Guardianship Papers (if applicable)</li> <li>• Copy (front &amp; back) of Medicaid/Private Health Insurance Card</li> </ul>	
<b>7. Copy of Client's Court Order to Treatment (if applicable)</b>	
<b>8. Consents:</b> <ul style="list-style-type: none"> <li>• Consent for Client Treatment</li> <li>• Client Agreement</li> <li>• Consent for Medical Evaluation and Treatment</li> <li>• Consent for Client to Participate in Outings &amp; Wilderness Experiences</li> <li>• Consent to Photograph and Film Client and Client's Artwork</li> <li>• Consent to Participate in Equine Assisted Psychotherapy</li> <li>• Consent to Receive Care from Eastern Band Of Cherokee Indians Mental Health/Substance Abuse Program</li> </ul>	
<b>9. Consents for Release of Information FROM the following:</b> <ul style="list-style-type: none"> <li>• Aftercare Counselor</li> <li>• School</li> <li>• Probation/Parole Officer</li> <li>• Mental Health Professional</li> </ul>	
<b>10. Consents for Release of Information TO the following:</b> <ul style="list-style-type: none"> <li>• Aftercare Counselor</li> <li>• School</li> <li>• Probation/Parole Officer</li> </ul>	
<b>11. Approved List of Client Contacts</b>	
<b>12. Any Prescription Medication Client is Currently Taking</b>	
<b>13. Any additional information which may be helpful</b>	

**Unity Healing Center  
Client Identifying Information**

To be completed by Client's Counselor or Referent

Client Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Date of Birth: _____ Age: _____ Sex: _____
Social Security Number: _____
In Which Federally Recognized Tribe is the Client Enrolled? _____

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**PARENTS:**

**Biological Mother's Name:** \_\_\_\_\_ Deceased?: \_\_\_\_\_  
Biological Mother's Maiden Name: \_\_\_\_\_  
Place of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_

**Biological Father's Name:** \_\_\_\_\_ Deceased?: \_\_\_\_\_  
Place of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_

**LEGAL GUARDIANS or OTHER PARENTING FIGURES:**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
Tribal Affiliation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**HEALTH CARE COVERAGE**

IHS Service Unit: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Eligible for Contract Health Services: Yes  No   
Name of IHS/CHS Authorizing Official: \_\_\_\_\_

Medicaid (Welfare): Yes  No  Medicaid No.: \_\_\_\_\_  
Medicaid State Filed In: \_\_\_\_\_ Eligibility Date: \_\_\_\_\_

State Health System enrolled: Yes  No  Enrollment No.: \_\_\_\_\_  
Name of State Health System: \_\_\_\_\_ Eligibility Date: \_\_\_\_\_

Private Insurance: Yes  No  Insurance No.: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

***Has Client Been Pre-Certified for Residential Treatment? Yes  No***

**REFERRING AGENT:**

Name and Title: \_\_\_\_\_  
Name of Program: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**PROBATION/PAROLE OFFICER:**

Name and Title: \_\_\_\_\_  
Name of Program: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Is the client court ordered to treatment? Yes  No   
What are the consequences of not completing treatment? \_\_\_\_\_  
What are the consequences of AWOL (running)? \_\_\_\_\_

**MENTAL HEALTH PROVIDER:**

Name and Title: \_\_\_\_\_  
Name of Program: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**PHYSICIAN:**

Name and Title: \_\_\_\_\_  
Name of Program: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Client Clinical Information**

To Be Completed by the Clients Counselor or Referent.

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

What are the problems that led to a referral at this time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Has the client had residential treatment for substance abuse? Yes  No   
Residential Facility \_\_\_\_\_ Date of Treatment \_\_\_\_\_ If not successfully completed, why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Has the client had outpatient treatment for substance abuse? Yes  No   
Outpatient Program \_\_\_\_\_ Counselor \_\_\_\_\_ Date of Treatment \_\_\_\_\_ 12-Step Experience Included? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*\* Please attach a copy of Discharge Summary, Assessments and any testing for #1 and #2.*

**Client Clinical Information**

**A. Substance Abuse/Dependence:**

3. Substance Abuse History

	Age First Used	Ages of Heaviest Use	Current Pattern	Date Last Used
Alcohol:				
Marijuana:				
Cocaine:				
Stimulants: (Crystal/Speed/Amphet)				
Inhalants:				
Hallucinogens: (LSD/Mushrooms/PCP)				
Opioids: (Heroin/Narcotics)				
Sedatives-Hypnotics (Valium/Phenobarbital)				
Steroids:				
Smoking Tobacco:				
Chewing Tobacco:				
Caffeine:				
Other:				
Other:				

4. Has the client had withdrawal or severe hangovers in the past? Yes  No   
 If YES, please describe: \_\_\_\_\_  
 \_\_\_\_\_

**B. Biomedical (Medical Problems & Physical Challenges):**

1. Is the client allergic to medications, foods, insect stings, plants? Yes  No   
 If YES, what is the client allergic to? \_\_\_\_\_

2. Does the client have any history of: Asthma , Diabetes , Seizure Disorder , Tuberculosis ,  
 Hepatitis , Heart Problems .

3. Other Medical Problems: \_\_\_\_\_  
 \_\_\_\_\_

4. Current Medications: \_\_\_\_\_  
 \_\_\_\_\_

5. **Is the client pregnant?** Yes  No  How many weeks? \_\_\_\_\_  
 Where is prenatal care being provided? \_\_\_\_\_  
 Last prenatal appointment? \_\_\_\_\_  
 Does client have children? Yes  No  If YES, please list ages: \_\_\_\_\_  
*Please send copy of current (no more than 2 weeks ago) results of pregnancy test.*

6. Is client physically challenged? (For example, does the client use a wheelchair, crutches, cane or does the client have vision or hearing difficulties?) \_\_\_\_\_

**C. Emotional/Behavior:**

1. Does the client have an Eating Disorder? Yes  No   
If YES, please describe: \_\_\_\_\_
2. Does the client have a history of fire setting? Yes  No   
If YES, please describe: \_\_\_\_\_
3. Has the client been hospitalized for emotional/mental problems? Yes  No

Hospital	Location	Dates of Treatment	Reason for Admission

*\* Please attach a copy of Discharge Summary, Assessments, and any testing for #3.*

4. Has the client seen a psychiatrist, psychologist, or counselor for emotional/mental problems?  
Yes  No

Therapist's Name	Phone Number	Date of Treatment	Reason for Therapy

*\* Please attach a copy of Discharge Summary, Assessments, and any testing for #4.*

5. Does the client have a history of suicide attempts? Yes  No

Date	Method	Name of Hospital	No. of Days in Hospital	Substance Abuse Involved

Additional information re: suicide attempts, such as intervention/treatment: \_\_\_\_\_  
\_\_\_\_\_

6. Is the client currently suicidal? Yes  No   
If YES, please describe: \_\_\_\_\_
7. Does the client have any history of self mutilation, i.e. cutting, burning? Yes  No   
If YES, please describe: \_\_\_\_\_
8. Is client enrolled in school? Yes  No  Last grade client completed: \_\_\_\_\_  
Has the client been in special education classes? Yes  No   
If YES, please describe: \_\_\_\_\_  
*\*Please send school information (grades, testing, current class schedule, etc.) with packet.*
9. Does the client have a history of violence? Yes  No   
If YES, please describe: \_\_\_\_\_
10. Has the client been involved in a gang? Yes  No   
If YES, which gang? \_\_\_\_\_ Gang Colors: \_\_\_\_\_  
Describe the client's involvement with the gang. \_\_\_\_\_
11. Does the client have current legal problems? Yes  No   
If YES, please describe: \_\_\_\_\_
12. Has the client had legal problems in the past? Yes  No   
If YES, please describe: \_\_\_\_\_

13. Is the client court-ordered to treatment at this time? Yes  No

*If YES, please attach a copy of the court order:* \_\_\_\_\_

(If the client has a Probation Officer or Parole Officer, please be sure that the Release of Information has been signed!)

**D. Treatment Acceptance/Resistance:**

1. Is the client willing to come to treatment voluntarily? Yes  No

**E. Recovery Environment:**

1. Who currently lives in the home with the client? (Please list their names, ages, and relationship to client): \_\_\_\_\_  
\_\_\_\_\_

2. Is there anyone currently living in the client's home who is in poor health? \_\_\_\_\_  
\_\_\_\_\_

3. Is there anyone currently living in the client's home who is an active substance abuser? \_\_\_\_\_  
\_\_\_\_\_

4. Is there anyone currently living in the client's home who is active in a program of recovery? \_\_\_\_\_  
\_\_\_\_\_

5. Does the client have any friends who are non-users or active in a program of recovery? \_\_\_\_\_  
\_\_\_\_\_

6. What types of 12-Step Meetings are available to the client after treatment? \_\_\_\_\_  
\_\_\_\_\_

7. Does the client have access to an Aftercare Program? Yes  No

8. What are the current plans for the client after treatment?  
Living Situation: \_\_\_\_\_  
School/Work: \_\_\_\_\_  
Aftercare Program: \_\_\_\_\_

**F. Additional Information:** \_\_\_\_\_  
\_\_\_\_\_

**G. *Diagnosis:*** (Include Substance Abuse and Mental Health Problems) \_\_\_\_\_  
\_\_\_\_\_

**H. Explain why Outpatient Treatment is not sufficient at this time:** \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Print Name of Client Interviewer                      Title

\_\_\_\_\_  
Signature of Client Interviewer                      Date

**History and Physical Examination**

To be completed by a Licensed Physician, Physician's Assistant, or Nurse Practitioner  
A Comprehensive Physical Exam Form May be Substituted

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Nation: \_\_\_\_\_

**Chief Complaint:**

- 1. The patient needs a complete History & Physical Examination within 1 month of admission to Unity Healing Center for Substance Abuse.
- 2. Current Medical Problems: \_\_\_\_\_  
\_\_\_\_\_
- 3. Current Medications & Doses: \_\_\_\_\_  
\_\_\_\_\_
- 4. Substance Abuse History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 5. Nicotine Uses (Smoking/Chewing Tobacco): \_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:**

Medical: HIV Tested? Yes  No   
Date and Results: \_\_\_\_\_  
HIV Risk Factors: (Circle Factors)      IV Drug Use      Unprotected Sex      Blood Transfusion  
If patient is sexually active, are condoms routinely used? Yes  No   
History of Hepatitis? Yes  No       Type of Hepatitis: \_\_\_\_\_  
Other: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Hospitalizations: \_\_\_\_\_  
Surgical: \_\_\_\_\_  
Injuries: \_\_\_\_\_  
OB-GYN: Menarche: \_\_\_\_\_ Menstrual History/Problems: \_\_\_\_\_  
LMP: \_\_\_\_\_ Last PAP: \_\_\_\_\_ Gravida: \_\_\_\_\_ Para: \_\_\_\_\_  
Contraception Used: \_\_\_\_\_  
Other: \_\_\_\_\_  
\_\_\_\_\_

**Family History:**

Medical: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychiatric: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Review of Systems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physical Examination:**

Vital Signs: P \_\_\_\_\_ T \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
General: \_\_\_\_\_

Speech Impairment: Yes  No  Describe: \_\_\_\_\_  
\_\_\_\_\_

Vision: Left \_\_\_\_\_ Right \_\_\_\_\_  
Hearing: Left \_\_\_\_\_ Right \_\_\_\_\_

**HEENT:**

Head: \_\_\_\_\_  
Eyes: \_\_\_\_\_  
Ears: \_\_\_\_\_  
Nose: \_\_\_\_\_  
Throat: \_\_\_\_\_  
Teeth/Gums: \_\_\_\_\_  
Neck: Thyroid: \_\_\_\_\_  
Nodes: \_\_\_\_\_

Chest:  
Breast: \_\_\_\_\_  
Lungs: \_\_\_\_\_

Cardiovascular:  
Heart: \_\_\_\_\_  
Pulses: \_\_\_\_\_

Abdomen: \_\_\_\_\_  
Back/Spine: \_\_\_\_\_  
Extremities: \_\_\_\_\_  
Genitalia: (Females-Pelvic) \_\_\_\_\_  
\_\_\_\_\_

Rectum: \_\_\_\_\_  
Skin/Hair/Nails: \_\_\_\_\_  
\_\_\_\_\_

**Physical Examination: (Continued)**

Neurological: \_\_\_\_\_  
Cranial Nerves II-XII: \_\_\_\_\_  
Motor Strength: \_\_\_\_\_  
Cerebellar: \_\_\_\_\_  
Gait: \_\_\_\_\_  
Finger to Nose/Heel to Shin: \_\_\_\_\_  
  
Deep Tendon Reflexes: \_\_\_\_\_  
Sensation: \_\_\_\_\_

\_\_\_\_\_ Immunizations: *Please attach a copy of patient's up to date immunization record.*  
\_\_\_\_\_ PPD: *Please attach a copy of patient's PPD results within the past year.*  
\_\_\_\_\_ Labs: *Please attach a copy of any recent labs.*

**Assessment and Plan:**

Medical Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan: \_\_\_\_\_  
\_\_\_\_\_

**Note: At most Residential Youth Treatment Centers for substance abuse, patients will be in treatment for 2 to 3 months. Please schedule any future critical appointments before treatment and other appointments after treatment.**

Are there any physical restrictions? \_\_\_\_\_  
\_\_\_\_\_

**Child/Adolescent Growth & Development**

**During pregnancy, did the biological mother have any of the following: (select all that apply)**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Amniocentesis      | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Vaginal Bleeding  | <input type="checkbox"/> German Measles        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> High Fever            | <input type="checkbox"/> Vaginal Infection | <input type="checkbox"/> Premature Labor       |
| <input type="checkbox"/> Diabetes Mellitus  | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Other Infection   | <input type="checkbox"/> Placenta Previa       |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> No Prenatal Care      | <input type="checkbox"/> Unknown           | <input type="checkbox"/> Excessive Weight Gain |
| <input type="checkbox"/> None               | <input type="checkbox"/> Other (specify) _____ |  |  |

**During pregnancy, did the biological mother use any of the following: (select all that apply)**

- |                                  |   |                                       |  |
|----------------------------------|---|---------------------------------------|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Prescription Drugs     | <input type="checkbox"/> Street Drugs | <input type="checkbox"/> Unknown               |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Over the Counter Drugs | <input type="checkbox"/> None         | <input type="checkbox"/> Other (specify) _____ |

Comments: \_\_\_\_\_  
\_\_\_\_\_

Any problems with labor and delivery?  No  Yes (specify) \_\_\_\_\_

Apgar Scores: \_\_\_\_\_

**Did the baby have any of the following after delivery: (select all that apply)**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Eye Problems          | <input type="checkbox"/> Intracranial Bleed | <input type="checkbox"/> Trouble Sucking        |
| <input type="checkbox"/> Apnea                 | <input type="checkbox"/> Fever/low temperature | <input type="checkbox"/> Jitteriness        | <input type="checkbox"/> 1 of Multiples (twins) |
| <input type="checkbox"/> Birth Defects         | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Physical Injury    | <input type="checkbox"/> Use of Oxygen          |
| <input type="checkbox"/> Blood Transfusions    | <input type="checkbox"/> Hydrocephalus         | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Ventilator             |
| <input type="checkbox"/> Bradycardia           | <input type="checkbox"/> Infection             | <input type="checkbox"/> Surfactant         | <input type="checkbox"/> Yellow Jaundice        |
| <input type="checkbox"/> Cord Around Neck      | <input type="checkbox"/> Intensive Care        | <input type="checkbox"/> Trouble Breathing  | <input type="checkbox"/> None                   |
| <input type="checkbox"/> Other (specify) _____ |  |   |   |

**Developmental Milestones – did the child have delays on any of the following: (select all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Rolling Over (2-6 mos.)     | <input type="checkbox"/> Toileting (24-36 mos.)     | <input type="checkbox"/> Tolerating Separation |
| <input type="checkbox"/> Sitting (6-12 mos.)         | <input type="checkbox"/> Dressing Self (24-36 mos.) | <input type="checkbox"/> Playing Cooperatively |
| <input type="checkbox"/> Standing (8-16 mos.)        | <input type="checkbox"/> Feeding Self               | <input type="checkbox"/> Talking               |
| <input type="checkbox"/> Walking (8-16 mos.)         | <input type="checkbox"/> Sleeping Alone             | <input type="checkbox"/> None                  |
| <input type="checkbox"/> Engaging Peers (24-36 mos.) |   |  |

**Has the child had any of the following: (select all that apply)**

**Brain Disorders**

- Confusion
- Headaches
- Coordination Problems
- Muscle Weakness
- Staring
- Tremors
- Tics (motor/vocal)
- Head injuries
- Seizures
- None
- Other (specify): \_\_\_\_\_

**Infections**

- Chicken Pox
- Ear Infections
- Encephalitis
- High Fevers
- Measles
- Mumps
- Meningitis
- Pneumonia
- Sinus Infections
- Whooping Cough
- None
- Other (specify): \_\_\_\_\_

**Hormone Problems**

- Obesity
- Thyroid
- Early Puberty
- Late Puberty
- None
- Other (specify): \_\_\_\_\_

**Muscle/Bone Problems**

- Scoliosis
- Spasticity
- None
- Other (specify): \_\_\_\_\_

**Heart/Lung Problems**

- Asthma
- Chest Pain
- Murmur
- Surgery
- Congenital Heart Disease
- None
- Other (specify): \_\_\_\_\_

**GI Problems**

- Constipation
- Diarrhea
- Soiling
- Vomiting
- None
- Other (specify): \_\_\_\_\_

**Skin Disorders**

- Acne
- Birth Marks
- Eczema
- Hair Loss
- None
- Other (specify): \_\_\_\_\_

<p><b>Kidney Problems</b></p> <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Daytime Wetting <input type="checkbox"/> Infections <input type="checkbox"/> None <input type="checkbox"/> Other (specify): _____	<p><b>Sensory Problems</b></p> <input type="checkbox"/> Auditory <input type="checkbox"/> Tactile <input type="checkbox"/> Visual <input type="checkbox"/> None <input type="checkbox"/> Other (specify): _____	<p><b>Sexual Problems</b></p> <input type="checkbox"/> Birth Control <input type="checkbox"/> Masturbation <input type="checkbox"/> Promiscuity <input type="checkbox"/> None <input type="checkbox"/> Other (specify): _____
<p><b>Injuries</b></p> <input type="checkbox"/> Broken Bones <input type="checkbox"/> Stitches <input type="checkbox"/> None <input type="checkbox"/> Other (specify): _____	<p><b>Poisoning</b></p> <input type="checkbox"/> Chemicals <input type="checkbox"/> Lead <input type="checkbox"/> None <input type="checkbox"/> Other (specify): _____	<p><b>Blood Disorders</b></p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising <input type="checkbox"/> None <input type="checkbox"/> Other (specify): _____
<p><b>Are immunizations up to date?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> (specify) _____</p> <p><i>(Please send copy of immunization record. It must be up to date with all required vaccines given!)</i></p>		

\_\_\_\_\_  
 Medical Provider's Signature

\_\_\_\_\_  
 Print Medical Provider's Name & Degree

Name of Clinic/Facility: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**CONTRACT HEALTH FORM**

***TO WHOM IT MAY CONCERN:***

*This is to introduce \_\_\_\_\_ who is eligible to receive Contract Health Services from the Indian Health Facility \_\_\_\_\_.*

*The services which \_\_\_\_\_ is eligible to receive are:*

*(Please list the services):*

\_\_\_\_\_  
Signature of an authorized Contract Health Representative

\_\_\_\_\_  
Date

**Due to a request by the Indian Health Service our hospital is required to set up a Patient Data Base System. This means that patients must answer certain questions which can then be placed on a master file in Albuquerque, NM.**

PLEASE COMPLETE THE FOLLOWING:

Chart No.: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Tribe \_\_\_\_\_ Degree \_\_\_\_\_

Name: \_\_\_\_\_ MALE or FEMALE (Circle One)  
Last First Middle

Address: \_\_\_\_\_ Live on Indian Land? YES or NO  
P.O. Box, Route, Hwy., Street Name, City, State, Zip Code

Community In Which You Live: \_\_\_\_\_ Name of Birthplace: \_\_\_\_\_  
City & State

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**EMPLOYMENT STATUS**

Name of Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Employer's Telephone Number: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Spouse's Employer's Telephone Number: \_\_\_\_\_

Employment Status: Full Time Part Time Unemployed Self-Employed Retired Active Military

Mother's Full Name Maiden: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Father's Full Name: \_\_\_\_\_ Birthplace: \_\_\_\_\_

**EMERGENCY CONTACT/NEXT OF KIN**

Name Full Complete: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
P.O. Box, Route, Hwy., Street Name, City, State, Zip

**INSURANCE INFORMATION**

Medicare No. \_\_\_\_\_ Hospital Date: \_\_\_\_\_ Medical Date: \_\_\_\_\_

Medicaid No. \_\_\_\_\_ Effective: \_\_\_\_\_

(We need your Medicaid Card for each month you visit the hospital.)

Private Insurance Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber ID Number/Policy: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Policy Holder's Name(s): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**VETERAN INFORMATION**

Are you a veteran? YES or NO Service Branch (Last): \_\_\_\_\_ Injuries in Service: YES or NO

Service Entry Date: \_\_\_\_\_ Service Separation Date: \_\_\_\_\_

Eligibility for Care: Direct Only \_\_\_\_\_ CHS & Direct \_\_\_\_\_

Signature \_\_\_\_\_

***The Business Office Needs A Copy Of Your Insurance Card For Billing Purposes. Please Sign The Release Of Information Assignment of Benefits Form.***

**AUTHORIZATION TO FURNISH INFORMATION AND ASSIGNMENT OF  
BENEFITS**

I authorize the release of information concerning health care provided to me at Indian Health Service or Medicare, Medicaid and other appropriate insurance agencies. I further authorize the payment of the Indian Health Service on my behalf. This authorization covers previous visits and will continue in effect for the lifetime of this policy, unless I revoke it at a future date.

\_\_\_\_\_  
Patient Signature and/or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

IS THIS A FAMILY POLICY – LIST DEPENDENTS

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PUBLIC HEALTH SERVICE  
INDIAN HEALTH SERVICE

**PRIVACY ACT SIGNATURE FORM**

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I have read the Privacy Act Notice. I have been informed that my record is or will be kept in the Health and Medical Records System at:

**Cherokee Indian Hospital**  
**Cherokee, North Carolina 28719**

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I understand that the information given by me and/or collected and stored in my health record is necessary for Indian Health Service staff or Indian Health Service contractors to provide services for my health and well being. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person, unless specified as routine use (listed on the "Why We Ask Questions" notice), without my signed consent.

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Signature of Individual

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Date

---

Signature of Guardian for Minor or Court  
Appointed Guardian

---

Date

---

Signature and Title of IHS or Contract  
Employee

---

Date

---

**"THIS FORM IS NOT A PREREQUISITE TO PROVIDING SERVICES"**

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Original in the individual's health record  
Copy to Individual

GPO: 1993 0 - 337-209

IHS-520 (Rev. 10/98)



## INFORMED CONSENT FOR REHABILITATION SERVICES

I hereby voluntarily apply for and consent for \_\_\_\_\_ to receive ADOLESCENT RESIDENTIAL MENTAL HEALTH SERVICES provided by Unity Healing Center. This consent applies to my child, or my ward. Because my child has the right to refuse services at any time, I understand and agree that continued participation implies voluntary informed consent. In this Consent, the terms "patient" and "resident" are used interchangeably.

### LIMITATIONS OF SERVICES

I understand that Unity Healing Center's (UHC) services consist of: complete medical assessment and treatment as indicated, psychological evaluation, assessment, consultation, and therapeutic interventions and recreational, cultural and educational assessments and interventions. I understand that evaluation and assessment services may also include the use of psychological and neuropsychological tests if indicated. I understand that intervention services may include counseling and brief psychotherapy. The provision of services and continuing care is not based on the ability to pay; services are based on need for care.

**I understand that Unity Healing Center is not warranting a cure or offering any guarantee of results or improvement of any condition.**

### ASSUMPTION OF RISKS AND BENEFITS

Potential benefits of treatment include clarifying diagnosis and/or reducing medical, cultural, educational, emotional, behavioral, or relationship issues. I understand that alternative procedures available to my child or ward include: services provided by another residential facility, psychiatrist, or mental health professional or no treatment at all.

### LIMITS OF CONFIDENTIALITY

I understand and agree that all disclosures and communications are considered Protected Health Information (PHI) except to the extent that I authorize a release of information, or under certain other conditions listed below. I understand that Protected Health Information (PHI) may be released without my consent or authorization in the following circumstances recognized by Unity Healing Center policy, CFR 42, Part 2 Confidentiality Of Alcohol and Drug Abuse Patient Records, The Privacy Act and the IHS Notice of Privacy Practices as identified in the new HIPAA regulations:

**Child Abuse:** If UHC knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that UHC report such knowledge or suspicion to the local Child Protection Team and to the Tribal referral source

**Health Oversight:** If a complaint is filed against UHC to Indian Health Services on behalf of my child Indian Health Service has the authority to view all confidential mental health information from UHC records relevant to that complaint.

**Judicial or Administrative Proceedings:** If your child or ward is involved in a court proceeding and a request is made for information about your child or ward's diagnosis or treatment and the records thereof, such information is privileged under federal law, and UHC will not release information without the written authorization from you or your legal representative, or a subpoena of which you and your child or ward have been properly notified and you have failed to inform UHC that you are opposing the subpoena or a court order.

The privilege does not apply when your child or ward is being evaluated for a third party or where the evaluation is court ordered. You and your child or ward will be informed in advance if this is the case.

**Serious Threat to Health or Safety:** When your child or ward present a clear and immediate probability of physical harm to him/her self, to other individuals, or to society, UHC may communicate relevant information concerning the potential harm to the victim, appropriate family member, and law enforcement or other appropriate authorities.

I hold Unity Healing Center harmless for releasing information under any of the above conditions.

I also consent to the attachment of my child or ward's photograph to Unity Healing Center's files and on any report to aid in correct identification of my child or ward.

**STATEMENT OF UNDERSTANDING AND RECEIPT OF NOTICE**

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will expire automatically as follows. I understand that my consent for release of information will be considered valid for twelve (12) months following the date below. I acknowledge that I voluntarily consent to the preceding conditions and that this consent form is valid during any related claims. I certify that I have read this form or that it has been read and explained to me in terms that I understand. My questions have been answered to my satisfaction, all blank spaces on the form have been completed, and all statements of which I do not approve have been stricken. By signing this form, I understand and agree with the terms and conditions of this form.

\_\_\_\_\_  
Resident Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

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

\_\_\_\_\_  
Witness Signature

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

**Consent for Medical Evaluation, Immunizations and Treatment**  
To be completed and Signed by the Client, Parent/Guardian, and a Witness

Client's Name: \_\_\_\_\_

The purpose of this consent is to allow prompt treatment of medical conditions and injuries in the absence of parents/guardians.

**Unity Healing Center** will make every attempt to notify the Client's parent/guardian prior to the initiation of any emergency care or extensive medical or dental procedure.

Consent is hereby given to **Unity Healing Center** to provide or arrange for necessary mental, dental, immunizations, and emergency care, including HPV Vaccine (Fe), prescription and over-the-counter medications for the above named client.

**Importance of Accurate Immunizations**

Please review the list below of the *required* immunizations prior to admission. It is important we document a current record of your child's immunizations. The purpose is to maintain accurate immunizations and prevent repeat dosing of injections your child may have already had. The date of dosing helps to complete dosing in a series of injections. The last dates and number in the series are very important for accuracy. e.g. *Hepatitis B #2 October 15, 2010*, would indicate the resident's immunizations have been updated and he/she would need a *Hepatitis #3 injection* during admission to Unity and we could safely complete that schedule.

- |  |  |
|--|--|
| 1. DTP   | 6. Hepatitis A (geographic specific, usually 2 injections) |
| 2. Polio Series  | 7. Meningococcal (required for residential status)         |
| 3. Hepatitis B Series (3)  | 8. Influenza (Oct-Mar season)                              |
| 4. MMR Series (2)  | 9. PPD test  |
| 5. Varicella (2 possibly) – date of injection or annotated history of childhood disease. | 10. HPV Vaccination  |

Your child/Client's Medical Discharge Summary will document any immunizations received from Cherokee Indian Hospital Association (CIHA) or our facility during your child's admission.

*Thank you in advance for your cooperation in the care and safety of your prospective child.*

\_\_\_\_\_  
*Client Signature*

\_\_\_\_\_  
*DATE*

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*DATE*

\_\_\_\_\_  
*Witness Signature*

\_\_\_\_\_  
*DATE*

Revoke Date: \_\_\_\_\_

**Consent for Client to Participate in  
Outings & Wilderness Experiences**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

**Outings**

An important part of the treatment program is the outings which allow the client to explore the world outside the treatment center while clean and sober.

Outings are off site activities that may include, but are not limited to the following: outside 12-Step meetings, visits to museums, libraries, churches, college campuses, parks, movie theaters, or other forms of wholesome entertainment. Off site activities may also be planned to promote full participation in Aftercare; clients may tour outpatients counseling programs, or facilities which provide residential treatment or educational or job training opportunities.

**Wilderness Experiences**

The clients may also have an opportunity to go on wilderness outings to challenge themselves and build self-confidence. Client activities may include, but are not limited to hiking, riding horses, back-packing, canoeing, rock climbing, rappelling (lowering oneself down mountain sides with ropes and harnesses), white-water rafting, overnight camping, swimming, ropes course, building fires, and cooking.

Extensive precautions are taken to ensure that the wilderness outings are safe.

I, \_\_\_\_\_, agree to participate fully in outings and wilderness  
(Print Client Name)  
experiences as a part of my treatment at **Unity Healing Center**.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

I, hereby give my consent for \_\_\_\_\_ to participate in outings and  
(Print Client Name)  
wilderness experiences as part of treatment provided by **Unity Healing Center**.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Revoke Date: \_\_\_\_\_

**Consent to Photograph and Film Client and Artwork**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, \_\_\_\_\_, hereby give my consent for **Unity Healing Center**  
(Print Client Name)

(check items permission given for)

1. \_\_\_\_\_ to take and use photographs, slides, or films of myself as part of the treatment process and staff training.
2. \_\_\_\_\_ to take and use photographs, slides, or films of my anonymous artwork as part of the treatment process and staff training.

I understand that I have the right to be protected under the Federal Confidentiality Law and I do give my permission freely and of my own accord.

I understand that I may revoke this consent for release of information at any time. However, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.

If no date of revocation is specified, this consent will expire 1 year from the date of signature below.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Revoke Date: \_\_\_\_\_

**Consent for Release of Confidential Information  
From the Client's Aftercare Counselor**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, _____ (Print Client Name)	SSN: _____ Date of Birth: _____
<b>AUTHORIZE: THE CLIENT'S AFTERCARE COUNSELOR:</b>	
Name and Title: _____	
Name of Program: _____	
Address: _____	
City: _____ State: _____	
Phone #: ( ) _____ Fax #: _____	
<b>TO RELEASE THE FOLLOWING INFORMATION:</b>	
1. A completed Residential Youth Treatment Center Intake Packet.	
2. After Counselor's assessment and treatment plans.	
3. Clinical information as needed before, during, and after treatment of the above name client whether in written reports, phone calls, or during visits from the Aftercare Counselor.	
4. Other: _____	
<b>TO:</b>	
Name of the Treatment Center: <b>Unity Healing Center</b>	
Address: <b>P.O. Box C-201 448 Sequoyah Trail Drive</b>	
City: <b>Cherokee</b> State: <b>NC</b> Zip Code: <b>28719</b>	
Phone #: <b>(828) 497-3958</b> Fax #: <b>(828) 497-6826</b>	
THE PURPOSE OF THE DISCLOSURE IS: To assist with the client's evaluation and treatment.	
<i>NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATIONS (42 CFR PART 2) &amp; THE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY &amp; ACCOUNTABILITY ACT (H.I.P.A.A.).</i>	
I understand that I may revoke this consent for release of information at any time. However, I do also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.	
If no date of revocation is specified, this consent shall expire 2 years from the discharge of the above named client.	
I certify that this request has been made freely, voluntarily, and without coercion.	
_____ Client Signature	_____ Parent/Legal Guardian Signature
_____ Date	_____ Date
_____ Witness Signature	_____ Revoke Date:
_____ Date	_____

**Consent for Release of Confidential Information  
From the Client's School**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, \_\_\_\_\_ SSN: \_\_\_\_\_  
(Print Client Name) Date of Birth: \_\_\_\_\_

**AUTHORIZE: THE CLIENT'S SCHOOL:**

School Principal's Name: \_\_\_\_\_  
School Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone #: ( ) \_\_\_\_\_ Fax #: \_\_\_\_\_

**TO RELEASE THE FOLLOWING INFORMATION:**

1. If the client is a Special Education student, a copy of the IEP (Individualized Educational Plan).
2. School Transcripts.
3. Current grade level
4. Current class list and performance status
5. School psychological assessments
6. School Counselor information
7. Immunization Records
8. Other: \_\_\_\_\_

**TO:**

Name of the Treatment Center: *Unity Healing Center*  
Address: *P.O. Box C-201 448 Sequoyah Trail Drive*  
City: *Cherokee* State: *NC* Zip Code: *28719*  
Phone #: *(828) 497-3958* Fax #: *(828) 497-6826*

**THE PURPOSE OF THIS DISCLOSURE IS:** To assist with the client's ongoing schooling during treatment.

*NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATIONS (42 CFR PART 2) & THE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (H.I.P.A.A.).*

I understand that I may revoke this consent for release of information at any time. However, I do also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.

If no date of revocation is specified, this consent shall expire 1 year from the discharge of the above named client.

I certify that this request has been made freely, voluntarily, and without coercion.

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Parent/Legal Guardian Signature Date

\_\_\_\_\_  
Witness Signature Date

Revoke Date: \_\_\_\_\_

**Consent for Release of Confidentiality Information  
From the Client's Probation/Parole Officer**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, \_\_\_\_\_ SSN: \_\_\_\_\_  
(Print Client Name) Date of Birth: \_\_\_\_\_

**AUTHORIZE: THE CLIENT'S PROBATION/PAROLE OFFICER:**

Name and Title: \_\_\_\_\_  
Name of Program: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone #: ( ) \_\_\_\_\_ Fax #: \_\_\_\_\_

**TO RELEASE THE FOLLOWING INFORMATION:**

1. Legal Records including arrests, charges, incarcerations, detentions, probations, and current legal status.
2. If the client was Court Ordered to treatment, a copy of the Court Order.
3. Other: \_\_\_\_\_

**TO:**

Name of the Treatment Center: *Unity Healing Center*  
Address: *P.O. Box C-201 448 Sequoyah Trail Drive*  
City: *Cherokee* State: *NC* Zip Code: *28719*  
Phone #: *(828) 497-3958* Fax #: *(828) 497-6826*

THE PURPOSE OF THE DISCLOSURE IS: To assist with the client's evaluation and treatment.

*NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATIONS (42 CFR PART 2) & THE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (H.I.P.A.A.).*

I understand that I may revoke this consent for release of information at any time. However, I do also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.

If no date of revocation is specified, this consent shall expire 1 year from the discharge of the above named client.

I certify that this request has been made freely, voluntarily, and without coercion.

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Parent/Legal Guardian Signature Date

\_\_\_\_\_  
Witness Signature Date

Revoke Date: \_\_\_\_\_

**Consent for Release of Confidential Information  
From the Mental Health Professional**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, _____ (Print Client Name)	SSN: _____ Date of Birth: _____
<b>AUTHORIZE: THE CLIENT'S MENTAL HEALTH PROFESSIONAL:</b>	
Name and Title: _____	
Name of Program: _____	
Address: _____	
City: _____ State: _____	
Phone #: ( ) _____ Fax #: _____	
<b>TO RELEASE THE FOLLOWING INFORMATION:</b>	
1. Psychiatric, psychological, or mental health clinical interview assessment.	
2. Psychological testing.	
3. Treatment Summaries.	
4. Other: _____	
<b>TO:</b>	
Name of the Treatment Center: <b>Unity Healing Center</b>	
Address: <b>P.O. Box C-201 448 Sequoyah Trail Drive</b>	
City: <b>Cherokee</b> State: <b>NC</b> Zip Code: <b>28719</b>	
Phone #: <b>(828) 497-3958</b> Fax #: <b>(828) 497-6826</b>	
THE PURPOSE OF THE DISCLOSURE IS: To assist with the client's evaluation and treatment.	
<i>NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATIONS (42 CFR PART 2) &amp; THE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY &amp; ACCOUNTABILITY ACT (H.I.P.A.A.).</i>	
I understand that I may revoke this consent for release of information at any time. However, I do also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.	
If no date of revocation is specified, this consent shall expire 1 year from the discharge of the above named client.	
I certify that this request has been made freely, voluntarily, and without coercion.	
_____ Client Signature	_____ Date
_____ Parent/Legal Guardian Signature	_____ Date
_____ Witness Signature	_____ Date
	Revoke Date: _____

**Consent for Release of Confidential Information  
To the Client's Aftercare Counselor**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, \_\_\_\_\_  
(Print Client Name)

SSN: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**AUTHORIZE:**

Name of the Treatment Center: **Unity Healing Center**  
Address: **P.O. Box C-201 448 Sequoyah Trail Drive**  
City: **Cherokee** State: **NC** Zip Code: **28719**  
Phone #: **(828) 497-3958** Fax #: **(828) 497-6826**

**TO RELEASE THE FOLLOWING INFORMATION:**

1. Clinical information provided as needed during treatment of the above named client whether in written reports, phone calls, or during visits from the Aftercare Counselor.
2. A copy of the Discharge Summary.
3. Other: \_\_\_\_\_

**TO: CLIENT'S AFTERCARE COUNSELOR**

Counselor's Name & Title: \_\_\_\_\_  
Name of Program: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone #: ( ) \_\_\_\_\_ Fax #: \_\_\_\_\_

**THE PURPOSE OF THE DISCLOSURE IS:** To assist with the client's evaluation and treatment.

*NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATIONS (42 CFR PART 2) & THE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (H.I.P.A.A.).*

I understand that I may revoke this consent for release of information at any time. However, I do also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.

If no date of revocation is specified, this consent shall expire 2 years from the discharge of the above named client.

I certify that this request has been made freely, voluntarily, and without coercion.

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Parent/Legal Guardian Signature Date

\_\_\_\_\_  
Witness Signature Date

Revoke Date: \_\_\_\_\_

**Consent for Release of Confidential Information  
To the Client's Probation/Parole Officer**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, _____ (Print Client Name)	SSN: _____ Date of Birth: _____
<b>AUTHORIZE:</b>	
Name of the Treatment Center: <b>Unity Healing Center</b>	
Address: <b>P.O. Box C-201 448 Sequoyah Trail Drive</b>	
City: <b>Cherokee</b> State: <b>NC</b> Zip Code: <b>28719</b>	
Phone #: <b>(828) 497-3958</b> Fax #: <b>(828) 497-6826</b>	
<b>TO RELEASE THE FOLLOWING INFORMATION:</b>	
1. Clinical information provided as needed during treatment of the above named client whether in written reports, phone calls, or during visits from the Aftercare Counselor.	
2. A copy of the Discharge Summary.	
3. Other: _____	
<b>TO: CLIENT'S PROBATION OFFICER OR PAROLE OFFICER</b>	
Name and Title: _____	
Name of Program: _____	
Address: _____	
City: _____ State: _____	
Phone #: ( ) _____ Fax #: _____	
THE PURPOSE OF THE DISCLOSURE IS: To assist with the client's evaluation and treatment.	
<i>NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATIONS (42 CFR PART 2) &amp; THE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY &amp; ACCOUNTABILITY ACT (H.I.P.A.A.).</i>	
I understand that I may revoke this consent for release of information at any time. However, I do also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.	
If no date of revocation is specified, this consent shall expire 1 year from the discharge of the above named client.	
I certify that this request has been made freely, voluntarily, and without coercion.	
_____ Client Signature	_____ Parent/Legal Guardian Signature
_____ Date	_____ Date
_____ Witness Signature	_____ Revoke Date:
_____ Date	_____

**Consent for Release of Confidential Information  
To the Client's School**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, _____ (Print Client Name)	SSN: _____ Date of Birth: _____
<b>AUTHORIZE:</b>	
Name of the Treatment Center: <b>Unity Healing Center</b>	
Address: <b>P.O. Box C-201                      448 Sequoyah Trail Drive</b>	
City: <b>Cherokee</b> State: <b>NC</b> Zip Code: <b>28719</b>	
Phone #: <b>(828) 497-3958</b> Fax #: <b>(828) 497-6826</b>	
<b>TO RELEASE THE FOLLOWING INFORMATION:</b>	
1. Academic information provided as needed during treatment of the above named client whether in written reports, phone calls, or during visits form the client's teacher or designated school representative.	
2. A copy of the Treatment Center's Education Specialist's Summary.	
3. Other: _____	
<b>TO: CLIENT'S SCHOOL</b>	
Principal's Name: _____	
School's Name: _____	
Address: _____	
City: _____ State: _____	
Phone #: ( ) _____ Fax #: _____	
THE PURPOSE OF THE DISCLOSURE IS: To assist with the client's evaluation and treatment.	
<i>NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATIONS (42 CFR PART 2) &amp; THE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY &amp; ACCOUNTABILITY ACT (H.I.P.A.A.).</i>	
I understand that I may revoke this consent for release of information at any time. However, I do also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.	
If no date of revocation is specified, this consent shall expire 1 year from the discharge of the above named client.	
I certify that this request has been made freely, voluntarily, and without coercion.	
_____ Client Signature	_____ Date
_____ Parent/Legal Guardian Signature	_____ Date
_____ Witness Signature	_____ Date
	Revoke Date: _____

**Consent for Release of Confidential Information  
To the Mental Health Professional**

To be Completed and Signed by the Client, Parent/Guardian and a Witness

I, _____ (Print Client Name)	SSN: _____ Date of Birth: _____
<b>AUTHORIZE:</b>	
Name of the Treatment Center: <i>Unity Healing Center</i>	
Address: <i>P.O. Box C-201                   448 Sequoyah Trail Drive</i>	
City: <i>Cherokee</i> State: <i>NC</i> Zip Code: <i>28719</i>	
Phone #: <i>(828) 497-3958</i> Fax #: <i>(828) 497-6826</i>	
<b>TO RELEASE THE FOLLOWING INFORMATION:</b>	
1. Clinical information provided as needed during treatment of the above named client whether in written reports, phone calls or during visits from the Mental Health Therapist.	
2. Discharge Summaries.	
3. Other: _____	
<b>TO: CLIENT'S MENTAL HEALTH PROFESSIONAL</b>	
Counselor's Name & Title: _____	
Name of Program: _____	
Address: _____	
City: _____ State: _____	
Phone #: (    ) _____ Fax #: _____	
THE PURPOSE OF THE DISCLOSURE IS: To assist with the client's evaluation and treatment.	
<i>NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATIONS (42 CFR PART 2) &amp; THE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY &amp; ACCOUNTABILITY ACT (H.I.P.A.A.).</i>	
I understand that I may revoke this consent for release of information at any time. However, I do also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.	
If no date of revocation is specified, this consent shall expire 2 years from the discharge of the above named client.	
I certify that this request has been made freely, voluntarily, and without coercion.	
_____ Client Signature	_____ Parent/Legal Guardian Signature
_____ Date	_____ Date
_____ Witness Signature	_____ Revoke Date:
_____ Date	_____

Eastern Band of Cherokee Indians  
Health & Medical Division  
Cherokee Indian Hospital Authority  
Tsali Care Center

**NOTICE OF PRIVACY PRACTICES**

This Notice is Effective on April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION  
ABOUT YOU MAY BE USED AND DISCLOSED AND  
HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**WE ARE REQUIRED BY LAW  
TO PROTECT MEDICAL INFORMATION  
ABOUT YOU.**

We understand that medical information about you and your health is personal. Any health information that can be used to identify you is "Protected Health Information" (PHI) by law. We are committed to protecting medical information about you. We create a record of the care and service you receive from us. This medical information may be about health care we provide to you or payment for this health care. It may also be information about your past, present, or future medical condition. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our program or your health care provider.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information.
- Follow the terms of the Notice that is currently in effect.

We reserve the right to make changes and to make the new Notice effective for medical information we already have about you as well as any information we receive in the future.

If we make changes to the Notice, we will:

- Post the new Notice in our waiting area.
- Have copies of the new Notice available upon request.

We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy Notes" are notes made by your mental health professional made about a conversation during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than protected health information.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

- We have relied on that authorization or
- If the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you
- Explain your rights with respect to medical information about you
- Describe how and where you may file a privacy-related complaint

**WE MAY USE AND DISCLOSE MEDICAL INFORMATION  
ABOUT YOU IN SEVERAL CIRCUMSTANCES**

We use and disclose medical information about patients every day. This section of our Notice explains in some detail and gives examples of how we may use and disclose medical information about you in order to provide health care, obtain payment for that health care, and operate our business efficiently.

1. Treatment:

We will use and disclose medical information about you to provide health care treatment to you.

*Example: Jane is a patient at the Women's Wellness Clinic. The receptionist may use medical information about Jane when setting up an appointment. The nurse practitioner will likely use medical information about Jane when reviewing Jane's condition and ordering a blood test. The laboratory technician will likely use medical information about Jane when processing or reviewing her blood test results. If, after reviewing the results of the blood test, the nurse practitioner concludes that Jane should be referred to a specialist, the nurse may disclose medical information about Jane to the specialist to assist the specialist in providing appropriate care to Jane.*

## 2. Payment:

We use and disclose medical information about you to obtain payment for health care services that you received.

*Example: Jane is a patient at the Cherokee County Clinic and she has private insurance. During an appointment with a nurse practitioner, the nurse practitioner ordered a blood test. The billing clerk will use medical information about Jane when she prepares a bill for services provided at the appointment and the blood test. Medical information about Jane will be disclosed to her insurance company when the billing clerk sends in the bill.*

*Example: The nurse practitioner referred Jane to a specialist. The specialist recommended several complicated and expensive tests. The specialist's billing clerk may contact Jane's insurance company before the specialist runs the tests to determine whether the plan would pay for the test.*

## 3. Health Care Operations:

We may use and disclose medical information about you for "health care operations." These "health care operation" activities allow us to improve the quality of care we provide and reduce health care costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications and performance of health care providers taking care of you.
- Providing training programs for students, trainees, health care providers or non-health care professionals to help them practice or improve their skills.
- Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Improving health care and lowering costs for groups of people who have similar health problems and helping to manage and coordinate the care for these groups of people.
- Cooperating with outside organizations that assess the quality of the care others and we provide including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

*Example: Jane was diagnosed with diabetes. The Diabetes Program used Jane's medical information from all of the Diabetes Program patients diagnosed with diabetes – to develop an educational program to help patients recognize the early symptoms of diabetes. (Note: The educational program would not use any specific patient identifiers without their permission).*

*Example: Jane complained that she did not receive appropriate health care. Cherokee Indian Hospital reviewed Jane's record evaluate the quality of the care provided to Jane. Cherokee Indian Hospital also discussed Jane's care with its attorney.*

## 4. Persons involved in your care:

We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is important. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

*Example: Jane's husband regularly comes to Urgent Care with Jane for her appointments and he helps her with her medication. When the nurse practitioner is discussing a new medication, Jane invites her husband to come into the private room. The nurse practitioner discusses the new medication with Jane and Jane's husband.*

## 5. Uses and disclosures which do not require an authorization:

- **Required by law:** We will use and disclose medical information about you whenever we are required by federal, state and local law. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services.
- **To avert a serious threat to health or safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Public health activities:** We may use or disclose medical information about you to public health or legal authorities charged with preventing or controlling disease, injury (abuse, neglect or domestic violence) or disability (workers compensation) as required by law.

- **Health oversight activities:** We may disclose medical information about you to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include audits, investigations, inspections, and licensure.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney) pursuant to a HIPAA compliant document issued by a court of law.
- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes.
- **Organ Donation:** We may disclose medical information about you to a coroner, medical examiner or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Appointment reminders:** We may contact you with a reminder that you have an appointment for health services at our facility.
- **Treatment alternative:** We may recommend possible treatment alternatives and options that may be of interest to you, using your health information.
- **Directory:** We will use your name, general condition, religious affiliation, and location for directory purpose, unless you do not want your information listed. This information may be provided to members of the clergy and to others who ask for you by name.
- **Marketing:** We may use medical information about you to contact you in person or by other means to encourage you to use a product or service. In some instances, we may use medical information about you to send you a small promotional gift.
- **Research organizations:** We may use or disclose medical information about you for to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities, national security, intelligence activities and correctional institutions.
- **Case of abuse, neglect, or domestic violence:** We may use or disclose medical information about you if the information is required by law in case of abuse, neglect, or domestic violence situation.
- **Workers' Compensation:** We may use or disclose medical information about you if the information is required for the processing of a workers' compensation claim under relevant law.

6. Authorization:

Except for situations listed in Section 5, and in situations involving treatment, payment and for operations, we will not use or disclose medical information about you without "authorization" or signed permission from you or your personal representative. We may wish to use or disclose medical information about you and in those instances we will contact you to sign an authorization form. You may also ask us to disclose medical information and we will ask you to sign an authorization form. If you do authorize us to use or disclose medical information for another purpose, you may revoke your authorization at any time, in writing unless your authorization was always relied upon for some action.

<b>YOUR HEALTH INFORMATION RIGHTS</b>
---------------------------------------

You have several rights with respect to health information about you. This section of the Notice will briefly mention each of these rights.

**Right to a copy of this Notice:**

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area.

**Right to inspect and copy:**

You have the right to see or review and receive a copy of medical information about you. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing and you will have the right to have our decision reviewed. If you would like a copy of the information, we will charge you a fee to cover the costs of the copy, supplies, labor and postage.

**Right to have medical information amended:**

You have the right to request an amendment to any health information that is incorrect or incomplete. To amend your medical information, you must submit a written request along with a reason for the request. We are not required to amend health information that is accurate and complete. We will provide you with information about the procedure for addressing any disagreement with the denial.

**Right to an accounting of disclosures we have made:**

You have the right to receive an accounting (which means a detailed listing) of disclosures of health information that we have made after April 14, 2003. You may specify the time period, which may not be longer than 6 years. One accounting per 12 month period is free of charge, additional accounting will be subject to a fee.

The accounting will not include several types of disclosures, including disclosures for treatment, payment, or health care operations to you, certain government functions, and PHI released pursuant to an authorization or oral or incidental disclosures.

**Right to request restrictions on uses and disclosures:**

You have the right to request in writing, that we limit the use and disclosure of medical information about you for treatment payment and health care operations. We are not required to agree to your request.

If we do agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

**Right to request an alternative means or location:**

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any responsible request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing.

**YOU MAY FILE A COMPLAINT  
ABOUT OUR PRIVACY PRACTICES**

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint by contacting the location that provided you services or with the federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint.

You may bring your verbal complaint to the:  
HMD Medical Compliance Coordinator at 828-497-7458  
CIHA Medical Records Administration at 828-497-9163  
TCC Business Manager at 828-497-5048  
Hotline Number 1-800-455-9014  
Or  
Contact the Secretary of Health & Human Services

**ADDITIONAL NOTICE PROVISIONS**

**1. Acknowledgement of receipt:**

We include your acknowledgement of receipt of the Notice of Privacy Practices in your Medical Record.

If you have questions about information in this Notice or about our privacy policies, procedures or practices you can contact:

HMD Medical Compliance Coordinator at 828-497-7458  
CIHA Medical Records Administration at 828-497-9163  
TCC Business Manager at 828-497-5048

**Eastern Band of Cherokee Indians  
Cherokee Indian Hospital  
Summary of Notice of Privacy Practices**

Each time you go to a doctor, hospital, or other healthcare place, a record of that visit is made. Usually, this record contains your symptoms, the examination, test results, diagnosis, treatment given and a plan for further care or treatment. The information which we call your medical record is an important part of health care we provide for you. Although this record belongs to the facility that treated you, the information in the notes is yours and you have the right to this information. These notes are called "Protective Health Information (PHI)."

Psychotherapy Notes will only be used by the person generating the notes and kept separately from the medical record, unless you sign a separate authorization to release this information.

The following is our Notice of Privacy Practice that explains your rights and the steps we take to protect your health information. This notice tells you in detail how we will use your health information.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge receipt of the Eastern Band of Cherokee Notice of Privacy Practices at: **The Eastern Band of Cherokee Indians Hospital.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian for Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature and Title of Employee

\_\_\_\_\_  
Date

For Patients Unable To Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge the receipt of the Notice of Privacy Practices due to the following reason(s): \_\_\_\_\_

\_\_\_\_\_  
Signature of Staff

\_\_\_\_\_  
Date

**I hereby certify that the patient is refusing to acknowledge the Notice of Privacy Practices.**

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

A-Na-Le-Ni-Sgi  
(Those who are beginning)

Name: \_\_\_\_\_  
Chart No.: \_\_\_\_\_

**Summary of Notice of Privacy Practice**

Each time you go to a doctor, hospital, or other healthcare place, a record of that visit is made. Usually, this record contains your symptoms, the examination, test results, diagnosis, treatment given and a plan for further care or treatment. The information which we call your medical record is an important part of health care we provide for you. Although this record belongs to the facility that treated you, the information in the notes is yours and you have the right to this information. These notes are called "Protected Health Information". (PHI)

Psychotherapy notes will only be used by the person generating the notes and kept separately from the medical record, unless you sign a separate authorization to release this information.

The following is our Notice of Privacy Practice that explains your rights and steps we take to protect your health information. This notice tells you in detail how we will use your health information.

**Acknowledgement of Receipt of Notice of Privacy Practices**

I hereby acknowledge receipt of the Eastern Band of Cherokee Notice of Privacy Practices at:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian of Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

**For Patients Unable to Acknowledge Receipt**

I hereby certify that the patient was unable to acknowledge receipt of the Notice of Privacy Practices due to the following reason(s):

\_\_\_\_\_

\_\_\_\_\_  
Signature of Staff

\_\_\_\_\_  
Date

I hereby certify that the patient is refusing to acknowledge the Notice of Privacy Practices

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

A-Na-Le-Ni-Sgi  
59 Echota Church Road  
Cherokee, NC 28719

A-Na-Le-Ni-Sgi  
(Those who are beginning)

Name: \_\_\_\_\_  
Chart No.: \_\_\_\_\_

**INFORMED CONSENT**

**CONSENT FOR SERVICES:** I consent to receive services from EBCI Mental Health/Substance Abuse programs, or I consent to the above child/youth of legally incompetent adult to receive services, evaluation or counseling.

**RELEASE OF INFORMATION:** I understand that quality care requires a coordination of services. I authorize EBCI Mental Health/Substance Abuse programs to release information about me, or my child or ward, to EBCI Health and Medical and/or Cherokee Indian Hospital physicians or appropriately licensed health provider, for the purpose of filing for insurance compensation or for requesting compensation from Federal or State resources that may provide payment for services I receive including the release of information relating to the diagnosis and/or treatment of alcohol or substance abuse.

The EBCI Mental Health/Substance Abuse programs are sensitive to and have an obligation to protect your right to privacy and re-committed to holding confidential and information that give us exceptions noted in the Notice of Privacy Practice. Our staff may discuss client situations with other medical professionals as part of our treatment process to ensure that you are given the best possible care. All staff has been trained in maintaining your confidentiality according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I have read and understand all of the above, and freely consent and agree to all the foregoing conditions and information. I understand that this consent will remain in effect for the duration of treatment, and that I can revoke at any time except to the extent that services have already been provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

A-Na-Le-Ni-Sgi  
59 Echota Church Road  
Cherokee, NC 28719

UNITY HEALING CENTER

RM-40-4

Unity Healing Center
Informed Consent for Telehealth Consultations

Health care services are available by two-way interactive video communications. Referred to as "telehealth", this means that I may participate with a behavioral health care provider and/or family member(s) from a different location. Since this is different than the type of therapeutic intervention with which I am familiar, I understand and agree to the following:

- 1. The behavioral health care provider and/or family member(s) will be at a different location from me. A counselor or other behavioral health care provider will be at my location with me to assist in the consultation.
2. The behavioral health care provider may transmit or share electronically details of my treatment progress, test results or medical information with the behavioral health care provider who is at a different location.
3. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the behavioral health care provider or family members.
4. Video recordings may be taken of the telehealth consultation, after I have given my written permission prior to recording. Video recordings and photos may be kept, viewed, and used for purposes including teaching, training or administrative purposes.
5. The counselor of the individual for whom the consultation occurred will record the pertinent information in the respective medical record which shall be maintained at Unity Healing Center.

Noting all the above, I understand that my participation in the process described (called "telehealth") is voluntary and constitutes a waiver of the usual right to counselor-resident privacy and may possibly increase the risk of disclosure of my medical data.

I further understand that I have the right to:

- 1. Refuse the telehealth consultation, or stop my participation in the telehealth consultation at any time.
2. Request that all personnel leave the room(s) to allow a private consultation with the off-site behavioral health care provider or family member(s).

I acknowledge that the health care providers involved have explained the consultations in a satisfactory manner and that all questions that I have asked about the consultations have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

Resident Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Resident Name Printed: \_\_\_\_\_

Primary Case Manager: \_\_\_\_\_ Date: \_\_\_\_\_

Location: \_\_\_\_\_ Unity Health Center, Cherokee, NC 28719

## CLIENT'S QUESTIONS AND ANSWERS ABOUT UNITY

Welcome to the Unity Health Center. Unity is a unique program that will help you learn to live an improved life without alcohol or drugs. Following is some information that will help you answer many questions prior to your arrival.

1. **What is Unity?** Unity is an inpatient treatment program that incorporates adventure based counseling with the 12 Step philosophy to help teach you to live an alcohol free, drug free lifestyle. Based upon the assessments that are completed upon admission, a Master Treatment Plan will be developed by you and your case manager to help guide you through your treatment. It will include areas such as school, recreation, individual and group therapy, cultural/spiritual activities, outdoor activities, lectures and one on one session on alcohol/drug education. This will be all tailored to your background and needs.
2. **What happens when I arrive at Unity?** When you arrive at Unity, you will be given a bedroom and your clothing will be checked in and searched. You will be given a tour of the facility and will begin the assessment phase of treatment. A staff member from each six different areas will interview you to gather information for the Master Treatment Plan. The Nurse will do a brief physical to check for medical problems and then you will move on to the other staff members (education, chemical dependency, cultural/spiritual, recreation, and mental health). After the assessments are completed you will begin working on orientation materials.
3. **How am I going to get there and how will I get home?** Your referring agent will work with you and your family to arrange transportation to and from Unity. We highly recommend that one member of your family accompany you so you and your family will better understand the treatment program at Unity. You need to bring with you a return ticket or arrangements for return home transportation. Your referring agent will assist you with this.
4. **How long will I be at Unity?** How long you stay at Unity depends on you, your needs, and how committed you are to working this program. The average length of stay is 3-4 months; however, shorter or longer periods may also be necessary for some people. Your Case Manager will give you an expected discharge date to work toward when you are first admitted. It will be updated throughout your stay depending upon your progress.
5. **What is Adventure Based Counseling (ABC)?** ABC is a style of counseling that uses outdoor activities to build trust, self-esteem, and leadership skills. The activities may include a Ropes Course, backpacking, canoeing, caving, rock climbing, bicycling, and various other activities. You will go on wilderness outings that last 5 days. ABC also incorporates the 12 Steps into the activities.
6. **Can I smoke while at Unity?** No, you cannot smoke or use any substance while at Unity. Unity is a tobacco free facility. Unity also treats nicotine as an addiction.
7. **What is expected of me while at Unity?** You are expected to be open and honest with peers and staff. You are expected to follow the expectations and guidelines of the Center. We would like for you to share your feelings with staff and peers. You are expected to participate in all scheduled activities.
8. **What can I expect from Unity?** You can expect to be treated with dignity and respect as a person, sincere, honest feedback from staff; care and concern for you as an individual; a structured, fair and impartial treatment, and individualized treatment.
9. **What kinds of things will I be doing?** You will be participating in outdoor activities such as canoeing, backpacking, walking, bicycling, sports activities, and various other outdoor activities. You will also be participating in one on one and group therapy, lectures, academic classes, cultural activities, and 12 step meetings. You will be involved in a daily schedule and will be involved in various community activities.
10. **Will I still need help when I go home?** Yes, you will need to follow a Continuing Care Plan that will be sent home with you. Recovery is a life-long process and the Continuing Care Plan is "insurance" to help you practice what you learn here at Unity. Unity staff, your referring agent, your family and you will discuss the goals for you prior to your discharge from Unity.

**SUGGESTED THINGS TO BRING WITH YOU TO TREATMENT**

CLOTHING LIST	PERSONAL HYGEINE LIST/OTHER ITEMS
1 Light Jacket	Deodorant (Non aerosol)
3 Pair Sweat Pants	Shampoo/Conditioner
3 Pair blue jeans/pants	Toothpaste/Toothbrush
7 shirts/sweat shirts	Comb/Brush
5 Pair shorts (no shorter than 4 inches above mid-knee)	Lotion
1 Light Jacket	Cartridge type/disposable razor
7 Pair sports socks	Shaving Cream
2 Pair tennis shoes	Tampons/Sanitary Napkins
1 Pair hiking boots/shoes	Foot Powder
1 Bathrobe	Hair Dryer
7 Pair briefs/panties	
4 Bras (females)	Stationary/stamps
Sleepwear	Laundry Detergent/softener if specific brand preferred
1 Pair swimming trunks (male)	Beach Towel
1 Swimsuit one-piece (female)	Makeup (allowed on certain levels)
1 Heavy Coat (seasonal)	
1 Pair gloves (seasonal)	
1 Winter hat (seasonal)	
(Dresses/skirts are optional – Must be knee length)	

**\*\*PLEASE BRING ANY SCHOOL BOOKS AND ASSIGNMENTS\*\***

**PRESCRIBED MEDICATIONS:**

Unity does not routinely administer drugs that have abuse potential, drugs that have significant undesirable side effects or known substantial risks. **Herbal preparations not regulated by the FDA, or medications not prescribed by a licensed provider are not given. Herbal preparations such as St. John’s Wort, valerian root, etc., will not be prescribed instead of regulated medication.** Bring all prescribed medications that you are currently using. Do not bring any vitamins or medicines not prescribed by your doctor. Make arrangements with your doctor to bring enough for 30 days. Medications will be secured when you arrive. You will then take them as prescribed.

**MONEY AND VALUABLES:**

You will not have a place to lock up your valuables during treatment. Bringing expensive jewelry is discouraged; however, jewelry is a level privilege of the Level System. We strongly encourage you not to bring more than \$50.00 with you to Unity. Your money will be deposited when you arrive in your personal Unity account and will be given as requested and approved through your Case Manager.

**DO NOT BRING**

- Anything with (written or pictured) profanity, obscene, violent, slogans; advertises tobacco, drugs or alcoholic beverages, satanic or is gang related.
- Tube or tank tops, halters, crops midriffs, and see through clothing.
- Excessive physically revealing or tight clothing and very low necklines.
- Pants that bag/sag.
- Short shorts, miniskirts, or spandex pants.
- Bandanas or drug related jewelry.
- Alcohol or anything containing alcohol.
- Anything in an aerosol can.
- Art supplies.
- Cigarettes, chewing tobacco, lighters, matches or other smoking paraphernalia.
- Weapons of any kind, knives, nail files, metal rat tail comb, or other sharp objects.
- Liquid or aerosol aftershave, perfume or cologne.
- Nail polish or polish remover.
- Playing cards, poker chips, or gambling devices.
- Cameras.
- Radio, MP3/IPOD, head phones, or music CDs.
- Straight razor or razor blades. \*

## ***Travel Information***

### ***Routes to Unity from Regional Airports***

These instructions are using the interstates, providing the best routes in case of inclement weather. If you are familiar with driving in mountainous terrain, and wish to attempt the most direct route, you may call Unity and ask for more detailed instructions.

#### ***From Asheville Airport:***

*Take a left out of the airport following the signs to Interstate 26*

*Precede approximately one half mile crossing over the Interstate*

*Turn left to North I-26 and continue on to Interstate 26 until it intersects with Interstate 40*

*I-26 and I-40 merge together. You will be bearing to the left onto I-40 West.*

*Continue on I-40 West until you reach exit 27*

*Bear to the right onto exit 27 where you will merge into US 74 West.*

*Stay on US 74 west following the signs to Cherokee.*

*Just a mile or so past Sylva, NC, US 441 north will merge with US 74 West. Continue west until US 441 breaks off and heads into Cherokee. Stay on US 441 North until your arrival in Cherokee. As you approach Cherokee you will pass through three stop lights. The 3<sup>rd</sup> one is a "T" intersection and you must turn right, going down the hill. Turn left onto Sequoyah Trail Drive and follow it to Unity.*

#### ***From Knoxville Airport:***

*Turn left out of the airport following the signs to Knoxville and Interstate 40. Turn onto I-40 East and continue to exit 27.*

*Bear to the right onto exit 27 where you will merge into US 74 West.*

*Stay on US 74 west following the signs to Cherokee.*

*Just a mile or so past Sylva NC, US 441 north will merge with US 74 West. Continue west until US 441 breaks off and heads into Cherokee. Stay on US 441 North until your arrival in Cherokee. As you approach Cherokee you will pass through three stop lights. The 3<sup>rd</sup> one is a "T" intersection and you must turn right, going down the hill. Turn left onto Sequoyah Trail Drive and follow it to Unity.*