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
Rebecca Hillane Lambert: Acting Director Ext. 202 rebecca.lambert@ihs.gov
Tracey Grant: Clinical Supervisor Ext. 209 tracey.grant@ihs.gov
| 1. | Client Identifying Information |
| 2. | Client Clinical Information |
| 3. | **History & Physical Exam** must be performed by a licensed physician (physician’s assistant or nurse practitioner as State Law allows) *within one month prior to admission*. A comprehensive Physical Exam Form may be substituted. |
| 4. | **Discharge Summaries and Psych Evaluations** |
| 5. | Copies of the following from the client’s physician or clinic:  
  • Immunization Record (up to date)  
  • Labs (any recent labs)  
  • PPD (Tuberculosis Skin Test within the past year)  
  • Face Sheet from client’s I.H.S. Health Facility/Clinic. |
| 6. | Copies of the following so that the client can be medically treated as needed:  
  • Social Security Card  
  • Birth Certificate  
  • Proof of Enrollment in a Federally Recognized Tribe  
  • Photo ID  
  • Guardianship Papers (if applicable)  
  • Copy (front & back) of Medicaid/Private Health Insurance Card |
| 7. | Copy of Client’s Court Order to Treatment (if applicable) |
| 8. | Consents:  
  • Consent for Client Treatment  
  • Client Agreement  
  • Consent for Medical Evaluation and Treatment  
  • Consent for Client to Participate in Outings & Wilderness Experiences  
  • Consent to Photograph and Film Client and Client’s Artwork  
  • Consent to Participate in Equine Assisted Psychotherapy  
  • Consent to Receive Care from Eastern Band Of Cherokee Indians Mental Health/Substance Abuse Program |
| 9. | Consents for Release of Information FROM the following:  
  • Aftercare Counselor  
  • School  
  • Probation/Parole Officer  
  • Mental Health Professional |
| 10. | Consents for Release of Information TO the following:  
  • Aftercare Counselor  
  • School  
  • Probation/Parole Officer |
| 11. | Approved List of Client Contacts |
| 12. | Any Prescription Medication Client is Currently Taking |
| 13. | Any additional information which may be helpful |
# Unity Healing Center

## Client Identifying Information

To be completed by Client’s Counselor or Referent

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Name</strong></td>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td><strong>City</strong>: State: Zip Code:</td>
<td>_______________________________________: _______________________________</td>
</tr>
<tr>
<td><strong>Home Phone</strong>: Work Phone:</td>
<td>______________________________: _______________________________</td>
</tr>
<tr>
<td><strong>Date of Birth</strong>: Age: Sex:</td>
<td>______________________________________: ______________________________</td>
</tr>
<tr>
<td><strong>Social Security Number</strong>:</td>
<td>_________________________________________________________________</td>
</tr>
<tr>
<td><strong>In Which Federally Recognized Tribe is the Client Enrolled?</strong></td>
<td>________________________________________________</td>
</tr>
</tbody>
</table>

**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): Medicaid No.: | Yes No: Medicaid State Filed In: Eligibility Date: |
| **State Health System enrolled**: Enrollment No.: Eligibility Date: | Yes No: Name of State Health System: ____________________ |

| Private Insurance: Insurance No.: | Yes 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

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

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 ☐

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
<th>Dates of Treatment</th>
<th>Reason for Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

* 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 ☐

<table>
<thead>
<tr>
<th>Therapist’s Name</th>
<th>Phone Number</th>
<th>Date of Treatment</th>
<th>Reason for Therapy</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

* 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 ☐

<table>
<thead>
<tr>
<th>Date</th>
<th>Method</th>
<th>Name of Hospital</th>
<th>No. of Days in Hospital</th>
<th>Substance Abuse Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

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 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:

<table>
<thead>
<tr>
<th>P</th>
<th>T</th>
<th>R</th>
<th>BP</th>
</tr>
</thead>
</table>

#### Height: ___________________  Weight: ___________________

**General:**

______________________________

**Speech Impairment:** Yes [ ] No [ ] Describe: ______________________

#### Vision:

<table>
<thead>
<tr>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
</table>

#### Hearing:

<table>
<thead>
<tr>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
</table>

#### 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: ________________________________

**Sensory Examination:**
- 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)
- [ ] Amniocentesis
- [ ] High Blood Pressure
- [ ] Vaginal Bleeding
- [ ] German Measles
- [ ] Anemia
- [ ] High Fever
- [ ] Vaginal Infection
- [ ] Premature Labor
- [ ] Diabetes Mellitus
- [ ] Kidney Problems
- [ ] Other Infection
- [ ] Placenta Previa
- [ ] Emotional Problems
- [ ] No Prenatal Care
- [ ] Unknown
- [ ] Excessive Weight Gain
- [ ] None
- [ ] Other (specify) ________________________________

**During pregnancy, did the biological mother use any of the following:** (select all that apply)
- [ ] Alcohol
- [ ] Prescription Drugs
- [ ] Street Drugs
- [ ] Unknown
- [ ] Tobacco
- [ ] Over the Counter Drugs
- [ ] None
- [ ] Other (specify) ________________________________

**Comments:**
- ________________________________
<table>
<thead>
<tr>
<th>Any problems with labor and delivery?</th>
<th>□ No</th>
<th>□ Yes (specify) ______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apgar Scores:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Anemia</th>
<th>Eye Problems</th>
<th>Intracranial Bleed</th>
<th>Trouble Sucking</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Apnea</td>
<td>Fever/low temperature</td>
<td>Jitteriness</td>
<td>1 of Multiples (twins)</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Birth Defects</td>
<td>Hernia</td>
<td>Physical Injury</td>
<td>Use of Oxygen</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Blood Transfusions</td>
<td>Hydrocephalus</td>
<td>Seizures</td>
<td>Ventilator</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Bradycardia</td>
<td>Infection</td>
<td>Surfactant</td>
<td>Yellow Jaundice</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Cord Around Neck</td>
<td>Intensive Care</td>
<td>Trouble Breathing</td>
<td>None</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Apgar Scores:</th>
<th>__________</th>
<th>__________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Rolling Over (2-6 mos.)</th>
<th>Toileting (24-36 mos.)</th>
<th>Tolerating Separation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sitting (6-12 mos.)</td>
<td>Dressing Self (24-36 mos.)</td>
<td>Playing Cooperatively</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Standing (8-16 mos.)</td>
<td>Feeding Self</td>
<td>Talking</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Walking (8-16 mos.)</td>
<td>Sleeping Alone</td>
<td>None</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Engaging Peers (24-36 mos.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Brain Disorders</th>
<th>Infections</th>
<th>Hormone Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>Chicken Pox</td>
<td>Obesity</td>
</tr>
<tr>
<td>Headaches</td>
<td>Ear Infections</td>
<td>Thyroid</td>
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<tr>
<td>Coordination Problems</td>
<td>Encephalitis</td>
<td>Early Puberty</td>
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<tr>
<td>Muscle Weakness</td>
<td>High Fevers</td>
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<tr>
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<tr>
<td>Tremors</td>
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<tr>
<td>Tics (motor/vocal)</td>
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<td>Head injuries</td>
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<td>Seizures</td>
<td>Sinus Infections</td>
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<td>None</td>
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**Muscle/Bone Problems**

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<th>Scoliosis</th>
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**Heart/Lung Problems**

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<thead>
<tr>
<th>Asthma</th>
<th>Chest Pain</th>
<th>Murmur</th>
<th>Surgery</th>
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**GI Problems**

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**Skin Disorders**

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### Kidney Problems
- [ ] Bed Wetting
- [ ] Daytime Wetting
- [ ] Infections
- [ ] None
- [ ] Other (specify): ____________________

### Sensory Problems
- [ ] Auditory
- [ ] Tactile
- [ ] Visual
- [ ] None
- [ ] Other (specify): ____________________

### Sexual Problems
- [ ] Birth Control
- [ ] Masturbation
- [ ] Promiscuity
- [ ] None
- [ ] Other (specify): ____________________

### Injuries
- [ ] Broken Bones
- [ ] Stitches
- [ ] None
- [ ] Other (specify): ____________________

### Poisoning
- [ ] Chemicals
- [ ] Lead
- [ ] None
- [ ] Other (specify): ____________________

### Blood Disorders
- [ ] Anemia
- [ ] Bleeding
- [ ] Bruising
- [ ] None
- [ ] Other (specify): ____________________

### Are immunizations up to date?  Yes [ ] No [ ] (specify) ____________________

*(Please send copy of immunization record. It must be up to date with all required vaccines given!)*

---

Medical Provider’s Signature: ____________________
Print Medical Provider’s Name & Degree: ____________________

Name of Clinic/Facility: ________________________________________________________________
Mailing Address: _____________________________________________________________________
City: _______________________________________ State: __________ Zip Code: ________________
Phone Number: __________________________ Fax Number: ______________________________

Revised May 2011

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:

<table>
<thead>
<tr>
<th>Chart No.:</th>
<th>Social Security No.:</th>
<th>Tribe</th>
<th>Degree</th>
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**Name:**

Last Name: ________________ First Name: ________________ Middle Name: ________________

**Gender:**

MALE or FEMALE (Circle One)

**Address:**

P.O. Box, Route, Hwy., Street Name, City, State, Zip Code

**Community In Which You Live:** ________________

**Name of Birthplace:** ________________

**Date of Birth:** ________________

**Marital Status:**

**Telephone Number:** ________________

### EMPLOYMENT STATUS

**Name of Employer:** ________________

**Address:** ________________

**Employer’s Telephone Number:** ________________

**Spouse’s Employer:** ________________

**Spouse’s Address:** ________________

**Spouse’s Employer’s Telephone Number:** ________________

**Employment Status:**

- Full Time
- Part Time
- Unemployed
- Self-Employed
- Retired
- Active Military

**Mother’s Full Name Maiden:** ________________

**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._

Revised May 2011
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

____________________

____________________

____________________

____________________
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

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.

Signature of Individual
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”

Original in the individual’s health record
Copy to Individual
IHS-520 (Rev. 10/98)
SERVICE AGREEMENT

1. AUTHORIZATION FOR HOSPITAL CARE AND EMERGENCY ROOM TREATMENT:
The undersigned voluntarily agrees to treatment and services that his/her physician deems necessary.

2. RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW:
Cherokee PHS may disclose all or any reasonable part of the patient’s record to include information pertaining to medical history, mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of the hospital’s charges to include but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit for any other purposes reasonably related to these activities. The undersigned understands that this authorization will remain in a long-term period of inpatient and outpatient services, unless revoked in writing prior to that date.

3. ASSIGNMENT OF INSURANCE BENEFITS – PRIVATE HEALTH INSURANCE:
I hereby authorize payment directly to the Cherokee Indian Hospital of the hospital benefits other wise payable to me but not to exceed the hospitals regular charges for this period of services or hospitalization. Authorization is not limited to private health insurance but may include other sources such as Medicare/Medicaid, Liability claims and/or reimbursable insurance for any services I receive.

4. MEDICAID:
State regulations require you to present a current identification card every time you are admitted or receive service. Every patient is required to submit an application for Medicaid if referred by a Physician, Benefits coordinator, Contract Health Service or other provider. Lack of compliance with the Medicaid application process may result in a denial for Contract Health Service until an application is completed.

5. MEDICARE:
This program covers hospitalization if it is determined that it is medically necessary for the patient to be admitted or receive health care. By signing this agreement I have given this facility a “Statement of Permit for Payment of Medicare Benefits to this Provider” it is my understanding that the Profession Review Organization and its agents may receive information needed to determine benefits payable.

6. NON-BENEFICIARY FINANCIAL AGREEMENT:
The undersigned agrees individually as follows: That in consideration for the services rendered to the patient, he/she obligates himself/herself and the patient to pay the account of the hospital in accordance with the regular rates and terms of this hospital. Any cost denied by an insurance agent or other responsible party, including co-payment and deductibles would be the responsibility of the parent/patient or guardian. Medicaid: If you do not identify yourself as a Medicaid recipient, you will be responsible for this bill. You will also be responsible for the Emergency Room charges for all Non-Emergency visits. Services not paid or covered under the Medicaid program will be billed to the patient or guardian. Medicare: You are expected to pay the Medicare deductible and co-insurance. If for some reason your care does not meet the requirements of your insurance agency you will be responsible for the entire bill.

7. PATIENT RIGHTS AND RESPONSIBILITIES:
Patient Rights and Responsibilities have been explained to me and I understand my rights as a patient or guardian. Advance Directives has been briefly explained to me and if I should have any questions, I must speak with my Physician or other designated Advance Directives liaison. Privacy Act: I have been given notice and read the Privacy Act Notice and the laws, which govern my rights as a patient.

8. CONTRACT HEALTH SERVICES:
I have received notice of my Contract Health Service (CHS) eligibility. I fully understand my responsibility under the CHS regulations. I understand the CHS is not an insurance program or an entitlement program. I understand that I must comply with the regulations outlined under the alternate resource notice.

9. AGREEMENT:
By signing this form I understand the contents of the service agreement and have received a copy. I understand the interpretation of this agreement, which was explained to me in English and/or in my native language. I also received the Health Insurance Portability and Accountability Act (HIPAA) Fact Sheet.

Patient’s Guardian/Guarantor Signature Date

Interviewer’s Signature Date

Patient Name: ____________________

Chart No.: ____________________
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
2. Polio Series
3. Hepatitis B Series (3)
4. MMR Series (2)
5. Varicella (2 possibly) – date of injection or annotated history of childhood disease.
6. Hepatitis A (geographic specific, usually 2 injections)
7. Meningococcal (required for residential status)
8. Influenza (Oct-Mar season)
9. PPD test
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

_________________________________________________ DATE
Parent/Guardian Signature

_________________________________________________ DATE
Witness Signature

Revoke Date: ________________________________
Consent for Client to Participate in
Outings & Wilderness Experiences

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

<table>
<thead>
<tr>
<th>Outings</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wilderness Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Extensive precautions are taken to ensure that the wilderness outings are safe.</td>
</tr>
</tbody>
</table>

I, ____________________________, agree to participate fully in outings and wilderness experiences as a part of my treatment at **Unity Healing Center**.

<table>
<thead>
<tr>
<th>Client Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, hereby give my consent for ____________________________ to participate in outings and wilderness experiences as part of treatment provided by <strong>Unity Healing Center</strong>.</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Witness Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Client Signature</th>
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<tr>
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<table>
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<tr>
<th>Witness Signature</th>
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</table>

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, __________________________________   SSN: ________________________
(Print Client Name)    Date of Birth: _________________

AUTHORIZED: THE CLIENT’s AFTERCARE COUNSELOR:

Name and Title: __________________________________________________________________
Name of Program: ________________________________________________________________
Address: ________________________________________________________________________
City: _______________________________________________State: _______________________
Phone #: (     ) _______________________________________ Fax #: _______________________

TO RELEASE THE FOLLOWING INFORMATION:
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: ___________________________________________________________________

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 2 years from the discharge of the above
named client.

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

_________________________________________   Date
Client Signature                          Parent/Legal Guardian Signature   Date

_________________________________________   Revoke Date: ________________________
Witness Signature                        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.

________________________  Date          __________________________  Date
Client Signature           Parent/Legal Guardian Signature
________________________  Date
Witness Signature          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 ___________________

Revoke Date: _______________________

Witness Signature ___________________ 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

<table>
<thead>
<tr>
<th>Field</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>I,</td>
<td>(Print Client Name)</td>
</tr>
<tr>
<td>SSN:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>AUTHORIZER</td>
<td>THE CLIENT’S MENTAL HEALTH PROFESSIONAL:</td>
</tr>
<tr>
<td>Name and Title:</td>
<td>Name and Title:</td>
</tr>
<tr>
<td>Name of Program:</td>
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<td>Address:</td>
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<td>Phone #:</td>
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<td>Fax #:</td>
<td>Fax #:</td>
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<tr>
<td>TO RELEASE THE FOLLOWING INFORMATION:</td>
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</tr>
<tr>
<td>1. Psychiatric, psychological, or mental health clinical interview assessment.</td>
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</tr>
<tr>
<td>2. Psychological testing.</td>
<td>2. Psychological testing.</td>
</tr>
<tr>
<td>3. Treatment Summaries.</td>
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<tr>
<td>4. Other:</td>
<td>4. Other:</td>
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<tr>
<td>TO:</td>
<td>TO:</td>
</tr>
<tr>
<td>Name of the Treatment Center:</td>
<td>Unity Healing Center</td>
</tr>
<tr>
<td>Address:</td>
<td>P.O. Box C-201 448 Sequoyah Trail Drive</td>
</tr>
<tr>
<td>City:</td>
<td>Cherokee</td>
</tr>
<tr>
<td>State:</td>
<td>NC</td>
</tr>
<tr>
<td>Zip Code:</td>
<td>28719</td>
</tr>
<tr>
<td>Phone #:</td>
<td>(828) 497-3958</td>
</tr>
<tr>
<td>Fax #:</td>
<td>(828) 497-6826</td>
</tr>
<tr>
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<tr>
<td>I certify that this request has been made freely, voluntarily, and without coercion.</td>
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<td>Date</td>
</tr>
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<td>Witness Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Revocation Date:</td>
<td>Revocation Date:</td>
</tr>
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</table>
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, __________________________________   SSN: ________________________
(Print Client Name)    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.
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.

<table>
<thead>
<tr>
<th>Client Signature</th>
<th>Date</th>
<th>Parent/Legal Guardian Signature</th>
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</table>

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, __________________________________   SSN: ________________________
(Print Client Name)    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.
3. Other: ________________________________________________________________

TO:  CLIENT’S PROBATION OFFICER OR PAROLE OFFICER
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.

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

Revoke Date: ___________________________

Witness Signature   Date

Revised May 2011
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, __________________________________   SSN: ________________________
(Print Client Name)    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. Academic information provided as needed during treatment of the above named client whether in written reports, phone calls, or during visits from the client’s teacher or designated school representative.
2. A copy of the Treatment Center’s Education Specialist’s Summary.
3. Other: ________________________________

TO:  CLIENT’S SCHOOL
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.

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         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: _________________

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 Mental Health Therapist.
2. Discharge Summaries.
3. Other: ________________________________________________________________

TO: CLIENT’S MENTAL HEALTH PROFESSIONAL
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: ______________________
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 to 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 overt 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.

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**YOUR HEALTH INFORMATION RIGHTS**

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
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.**

<table>
<thead>
<tr>
<th>Signature of Patient</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Guardian for Minor</td>
<td>Date</td>
</tr>
<tr>
<td>Signature and Title of Employee</td>
<td>Date</td>
</tr>
</tbody>
</table>

**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):

____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Signature of Staff</th>
<th>Date</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Signature of Employee</th>
<th>Date</th>
</tr>
</thead>
</table>
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
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: _________________
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**

<table>
<thead>
<tr>
<th>CLOTHING LIST</th>
<th>PERSONAL HYGEINE LIST/OTHER ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Light Jacket</td>
<td>Deodorant (Non aerosol)</td>
</tr>
<tr>
<td>3 Pair Sweat Pants</td>
<td>Shampoo/Conditioner</td>
</tr>
<tr>
<td>3 Pair blue jeans/pants</td>
<td>Toothpaste/Toothbrush</td>
</tr>
<tr>
<td>7 shirts/sweat shirts</td>
<td>Combs/Brush</td>
</tr>
<tr>
<td>5 Pair shorts (no shorter than 4 inches above mid-knee)</td>
<td></td>
</tr>
<tr>
<td>1 Light Jacket</td>
<td></td>
</tr>
<tr>
<td>7 Pair sports socks</td>
<td>Cartridge type/disposable razor</td>
</tr>
<tr>
<td>2 Pair tennis shoes</td>
<td></td>
</tr>
<tr>
<td>1 Pair hiking boots/shoes</td>
<td></td>
</tr>
<tr>
<td>1 Bathrobe</td>
<td></td>
</tr>
<tr>
<td>7 Pair briefs/panties</td>
<td></td>
</tr>
<tr>
<td>4 Bras (females)</td>
<td></td>
</tr>
<tr>
<td>Sleepwear</td>
<td></td>
</tr>
<tr>
<td>1 Pair swimming trunks (male)</td>
<td>Beach Towel</td>
</tr>
<tr>
<td>1 Swimsuit one-piece (female)</td>
<td>Makeup (allowed on certain levels)</td>
</tr>
<tr>
<td>1 Heavy Coat (seasonal)</td>
<td></td>
</tr>
<tr>
<td>1 Pair gloves (seasonal)</td>
<td></td>
</tr>
<tr>
<td>1 Winter hat (seasonal)</td>
<td></td>
</tr>
<tr>
<td>(Dresses/skirts are optional – Must be knee length)</td>
<td></td>
</tr>
</tbody>
</table>

**PERSONAL HYGEINE LIST/OTHER ITEMS**

- Deodorant (Non aerosol)
- Shampoo/Conditioner
- Toothpaste/Toothbrush
- Combs/Brush
- Cartridge type/disposable razor
- Shaving Cream
- Tampons/Sanitary Napkins
- Foot Powder
- Hair Dryer
- Laundry Detergent/softener if specific brand preferred
- Beach Towel
- Makeup (allowed on certain levels)

**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 3rd 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 3rd 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.