bacon street
YOUTH AND FAMILY SERVICES

Multiple Consent Form - Client

Client Name: _____

Instructions to Client: Please read and review each section of this form. If you need assistance, staff will assist you and answer any of your questions. If you wish to decline any of the consents, please indicate your declination on the line provided at the end of the multiple consent form. These consents are valid for the entire course of services, and after discharge (if applicable). Your signature at the end of the form indicates your review and consent. Thank You!

Treatment Authorization Form

In order to receive services you and/or your parent/guardian must sign the following consent for services. This consent is valid for the entire course of services, until discharge from Bacon Street Youth and Family Services.

Consent to Receive Services (Must be Signed): I consent to receive services provided by Bacon Street. Accordingly, I give my consent for Bacon Street to perform the following:

1. To provide psychological assessment, diagnosis, treatment planning, clinical and rehabilitative services, crisis response services, and emergency medical assistance.
2. To collect personal and medical information about me, this will be filed in a confidential electronic medical record.
3. To use this information for multiple purposes, including service provision by multiple providers or programs within Bacon Street, documentation of services, billing for services rendered, and internal and external review and audits for compliance with laws, regulation and accreditation.

Consent for Alcohol and Drug Screening

I consent to random alcohol breathalyzer and urine drug screening as requested by staff. There is no fee for alcohol breathalyzer screening. The fee for a basic 8 panel urine drug screen is $25.00, there are additional fees for other test panels and I agree to pay this fee, or arrange for financial assistance prior to screening.

Exchange of Medical Information with Primary Health Care Provider

My designated primary care provider is: _____

I give permission for Bacon Street to exchange confidential health information with my designated primary health care provider. This exchange of information is limited to the coordination of medical care. The information exchanged may include assessment and evaluation, diagnosis, treatment plan, progress reports, prescribed medications, lab studies, substance use information and HIV status. A separate signed Authorization for the Release of Confidential Information is required with this permission.

Contact after Discharge- Clinical

Bacon Street has my permission to contact me within twelve months following my discharge from the Bacon Street program or any program of the organization. The purpose of this contact is to assess my satisfaction with services, whether services were effective, and any unmet service needs.

Permission to Contact for Outreach Purposes

Bacon Street Youth and Family Services works hard to promote the services we provide through the continued relationship we have with our current and former clients and their families. A large portion of our funding is contingent on maintaining these positive relationships. Therefore: I give permission for staff and/or volunteers from Bacon Street Youth and Family Services to contact me in the future regarding the collection of success stories to support furthering the mission of the agency.

Acknowledgement of Video Surveillance

I acknowledge that I understand that Bacon Street Youth and Family Services has video surveillance in place in public areas of the agency offices to support safety and security requirements. I have been made aware that client sessions are not subjected to video surveillance unless notified in advance and with my direct permission.

I have reviewed and understand each of the above consent sections. My signature below documents my consent to each section of this form unless declined below.

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

I wish to decline the following: _____

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Client Medical History and Emergency Medical Information

(Please use black ink only)

Client Information:

Name: _____ Today's Date: _____
Last name Legal First Name Middle

Street Address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: _____ Race: _____

Religion: _____ Home Phone: _____ Work: _____

Cell/Alternate: _____ Email Address: _____

Emergency Contact Information

The following person(s) should be notified of my condition and whereabouts in case of an emergency:

Relative/Guardian: _____
Last Name First Name Relationship

Current Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Work: _____

Cell/Alternate: _____ Email Address: _____

Primary Care Physician ❑ None

Physician's Name: _____ Phone:_____

Address: _____

Date of Last Physical: _____ Date of last Dental Examination: _____

Insurance Information ❑ None

Primary Insurance: _____ Policy Number: _____

Primary Holder: _____ Primary Holder DOB: _____ Group Number: _____

Secondary Insurance: _____ Policy Number: _____

Primary Holder: _____ Primary Holder DOB: _____ Group Number: _____

Allergies ❑ No Known Allergies

Include Medication, Food and Allergic Reaction: Please Specify_____

Current Medications XNone (please use the back of this form for additional space)

Medication	Dosage/Time	Physician	Reason	Date Started	Date Discontinued

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Client Medical History and Emergency Medical Information (continued)

Advanced Directive ❑ Yes ❑ No

Please check the applicable response to the following questions: * Recent = Within Past 3 months	Yes	No	Unknown
1. Chronic Conditions:	❑	❑	❑
2. Recent* physical complaints:	❑	❑	❑
3. Communicable Diseases (including TB, HIV, Hepatitis)	❑	❑	❑
4. Handicaps/Restrictions on physical ability:	❑	❑	❑
5. Communication Problems:	❑	❑	❑
6. Past serious illnesses, injuries or hospitalizations:	❑	❑	❑
7. Serious illnesses and chronic conditions of client's parents. Siblings and significant others:	❑	❑	❑
8. Recent* drug abuse including alcohol, prescription and non-prescription medications and illicit drugs	❑	❑	❑
9. Past drug abuse including alcohol, prescription and non-prescription medications and illicit drugs:	❑	❑	❑
10. ❑ Recent* or ❑ Past usage of tobacco products:	❑	❑	❑
If you checked ***YES*** to any of the above questions, please explain (include dates, treatment and outcome):			
Sexual Health and Reproductive History (Children, Pregnancies, Abortions, Sexual Health Conditions):			

Other Medical Doctors

Physician	Specialty	Phone Number

Notice of Deemed Consent to HIV Blood Testing

Virginia LAW (32.1 – 49.1) authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to the law, in the event of such exposures, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the individual provider who may have been exposed. Pursuant to the law, you will be informed before any of your blood will be tested for HIV antibodies, the testing will be explained to you, and you will be given the opportunity to ask any questions you may have about the test.

Permission for Emergency Care and Transportation

Bacon Street Youth and Family Services has my permission, in an emergency, to provide necessary emergency First Aid treatment and/or to transport me, by the most appropriate transportation available, to the nearest medical facility, for the purpose of receiving care. I also give Bacon Street Youth and Family Services staff permission to release information required to aid in the emergency. This authorization expires upon termination of services. I hereby sign my name indicating that I understand and agree with the above statements.

_____ _____ _____

Client/Guardian Signature Date Witness

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Fall Risk Assessment

Client Name: _____

Date: _____ DOB: _____ Age: _____

Does Client have any of the fall risk elements listed below?	❑ Yes	❑ No
History		
Recent Falls (within the past six months)	❑ Yes	❑ No
Hypo/Hypertension	❑ Yes	❑ No
Low or unstable blood sugar	❑ Yes	❑ No
Physical Status		
Fatigue/weakness	❑ Yes	❑ No
Dizziness/balance problems	❑ Yes	❑ No
Impaired mobility	❑ Yes	❑ No
Sensory impairment	❑ Yes	❑ No
Seizure Disorder	❑ Yes	❑ No
Alteration in elimination	❑ Yes	❑ No
Intoxication or withdrawal	❑ Yes	❑ No
Mental Status		
Confused/illogical thinking, agitation, delirium	❑ Yes	❑ No
Impaired memory	❑ Yes	❑ No
Disorientation to person/place/time	❑ Yes	❑ No
Lack of familiarity with immediate surroundings	❑ Yes	❑ No
Inability to understand/follow instructions	❑ Yes	❑ No
Medication		
Drugs that have diuretic effect	❑ Yes	❑ No
Drugs that alter thought processes and/or hypotensive effect	❑ Yes	❑ No
Drugs that increase GI mobility	❑ Yes	❑ No

Fall Risk Score **Scoring Key: 0=No Risk** **1-3=Moderate Risk** **4 or higher=High Risk**

If Moderate Risk, implement and ensure risk assistance (monitoring, orientation to setting, instruction as needed to use or request ambulatory devices).

If High Risk, implement and ensure risk precautions (monitoring, orientation to setting, continuous supervision when walking or moving around, attend with client in the bathroom). Precautions included in ISP.

Comments:

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Demographic Questionnaire

Client Name: _____

Date: _____ DOB: _____ Age: ____

Please indicate where you reside:

- ❑ City of Williamsburg
- ❑ James City County
- ❑ City of Poquoson
- ❑ York County
- ❑ Newport News
- ❑ Hampton
- ❑ Other _____

Number in Household: _____

Approximate Household Income: (please check one)

- ❑ 0-24,999/year
- ❑ 25,000-49,999/year
- ❑ 50,000-74,999/year
- ❑ 75,000-99,999/year
- ❑ 100,000-149,999/year
- ❑ 150,000-199,999/year
- ❑ 200,000 and above

Do you have health insurance? (please check one) ❑ **Yes** ❑ **No**

Type of Insurance: _____ Parent(s) Age: _____

Client's Gender: _____ Client's Race/Ethnicity: _____

Latino/Latina? ❑ **Yes** ❑ **No**

Who referred you to Bacon Street Youth and Family Services? (please check and describe all that apply below)

- ❑ School (School Name): _____
- ❑ Court (Court Location): _____
- ❑ Social Services (County): _____
- ❑ Other Service Provider (Who?): _____
- ❑ Williamsburg Child Assessment Center at Colonial Behavioral Health
- ❑ Friend/Family Member
- ❑ Other (Please Describe): _____

THANK YOU for completing this data, which is collected to help us better understand the clients we are serving and to help us obtain funding.

Human Rights Acknowledgement

Client Name: _____ DOB: _____ Age: ____

I, _____ hereby acknowledge that I have received a copy of my rights and that they have been read and explained to me so that I understand them. I have also been informed of the Regional Advocate and how to contact that person.

Signed: _____ Date: _____
Client

_____ _____
Parent, Guardian or Authorized Person Staff Member Signature

_____ **was read his/her rights on** _____**.**
Client Name Date

These rights were reviewed and explained by: _____
Staff Member

The above named is unable/unwilling to sign that he/she understands these rights.

_____ _____
Staff Member Date

_____ rights were reviewed by staff indicated below with him/her on each listed date.
Client Name

Date	Client Signature	Staff Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Late or Missed Appointment, Late Cancellation and Intake Paperwork Policy

Thank you for choosing or continuing to choose Bacon Street! It has been and always will be our privilege to serve you. We have recently updated our policies regarding payment and missed appointments in order to ensure that we protect the valuable time of our clinicians to allow them to continue to meet the needs of their clients, and to ensure that Bacon Street as an agency continues to be able to afford to serve all who walk through our doors.

Beginning immediately, all active clients must have a credit card on file. Credit Cards will be stored electronically in our secure forum, but must be current. Additionally, the Missed/Late Cancellation Policy fees will be charged to the Credit Card on file. The policy is as follows:

- **Late Policy: If a client is more than 15 minutes late for a scheduled appointment, the client will need to reschedule with the clinician. The client will be billed for the missed appointment, per the Missed Appointment Policy Guidelines (received by all clients at intake.)**

- **Late Cancellations: Due to an increase in the number of late cancellations and no shows for appointments, we will be instituting a $50.00 fee for cancellations within 24 hours of the scheduled appointment.**

- **Missed Appointment: Effective immediately, Bacon Street Youth and Family Services will assess a $50 missed appointment fee for all clients who do not cancel and/or reschedule at least 24 hours in advance of their scheduled appointment.**

We understand that sometimes things happen, and will make exceptions on a case by case basis. **Please remember to confirm or reschedule appointments at least 12 hours prior to your appointment**. Thank you for your cooperation. Thank you in advance for your assistance in making Bacon Street the amazing place that it is by keeping your appointments and by recognizing the need to obtain fees for us to continue services for the clients in our community who need us!

Intake Paperwork Policy

Please make sure you complete the initial intake paperwork 2 business days (excluding the weekends) in advance. **Your appointment will have to be rescheduled if this paperwork is not received 2 business days in advance.**

I acknowledge that I have received this policy update on _____.

_____ _____

Client Signature Responsible Party's Signature