PATIENT ACKNOWLEDGEMENTS / CONSENTS

1. I agree to be evaluated by a member of the Bowen Center clinical staff. Following the evaluation, I will be asked to consent to specific treatment recommendations as stated in the treatment plan.
2. I understand these services are voluntary and that I may revoke consent at any time.
3. I understand therapy sessions are private and conversations during therapy cannot be recorded without consent from both the patient and provider.
4. I understand that Bowen Center medical staff will routinely verify that I am not receiving controlled substances from another provider via the INSPECT report ***(medication patients only).***
5. I understand that Bowen medical staff will submit prescription orders to the pharmacy that I have designated for the purpose of continued treatment. These prescriptions may include information that discloses I am a substance use patient (diagnosis, medication name). I can revoke this consent at any time unless Bowen Center has already acted in reliance on it. Expiration of this specific consent will be until the end of services or when a new consent is signed.
6. I understand that for my safety, my medication fill history may be obtained electronically from the pharmacy database to ensure thorough medication reporting.
7. I understand student nurses/interns may be involved in my treatment and I can refuse treatment that is provided by them at any time.
8. I have been offered a copy of my Bowen Center and ASPIN Rights and Responsibilities regarding services being provided. A copy of these Rights and Responsibilities will be posted in the office in which I will be receiving treatment, or I may review them on Bowen Center's website: www.bowencenter.org.
9. I have received a copy of Suicide Prevention Information. This is also available on Bowen Center's website: www.bowencenter.org ***(N/A for IPU – Patient will receive at discharge.)***
10. I have received a summary of Bowen Center's Notice of Privacy Practices. I am aware that detailed information is available upon request and is available on Bowen Center's website: www.bowencenter.org
11. I and/or the patient being admitted will be financially responsible to pay Bowen Center for any costs incurred to collect this debt, including but not limited to collection fees, interest fees, and attorney fees. I understand that some services may be court mandated. I understand also that some services may include preparation of reports, testimony, and other non-direct patient services.
12. **Financial (Payment, Charges & Billing)**
    - I understand these services will be charged at the rate discussed with me.
    - I agree to notify Bowen Center of changes that may affect my fee.
    - I understand it is required to supply written proof of financial status. Failure to provide this information in a timely manner shall disallow any discounted fees.
    - I understand that telephone consultations with the patient and/or family may be charged at the regular fee rate.
    - **I understand that payment is due at the time of service, and that all co-pays and deductibles are due at each visit.** Any other arrangements must be approved in advance.
    - I understand that I am responsible for any remaining balance after insurance has paid or if insurance does not pay.
    - I agree that in order for you to collect any amounts I may owe; you may contact me by telephone at any telephone number associated with my account. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of a dialing service, as applicable.
    - This is to advise you that unless otherwise requested, the Bowen Center will file all services with your insurance company and/or Medicare. If you request, we not bill your insurance company, you will be responsible for your entire balance.

By signing below, I acknowledge that the corresponding statements and information have been explained and reviewed with me, and I understand them. I voluntarily consent to participate in treatment.

Patient Signature	Date	Patient Printed Name	
Patient's Representative Signature (if applicable)	Date	Representative's Relationship to Patient	

For Office Use Only: ☐ Patient refused to sign per _____ *(Staff Initials)* ☐ Patient unable to sign per _____ *(Staff Initials)*

Patient Name: _____
MRN: _____
Location: _____

Disclosures of Substance Use Information

Federal Requirements

Federal regulations (42 CFR Part 2) protect the confidentiality of substance use disorder patient records. As a part 2 provider, Bowen Center is required to provide you a summary of these regulations in writing. These regulations cover any record reflecting a diagnosis identifying a patient as having or having had a substance use disorder which is initially prepared by Bowen Center in connection with the treatment or referral for treatment of a patient with a substance use disorder.

- Acknowledging the presence of patients: The presence of an identified patient in a health care facility or component of a health care facility which is publicly identified as a place where only substance use disorder diagnosis, treatment, or referral for treatment is provided may be acknowledged only if the patient's written consent is obtained or if an authorizing court order is entered in accordance with subpart E of 42 CFR part 2.
- Answering a request for a disclosure of patient records which is not permissible under the regulations in this part must be made in a way that will not affirmatively reveal that an identified individual has been, or is being, diagnosed or treated for a substance use disorder. An inquiring party may be provided a copy of the regulations in this part and advised that they restrict the disclosure of substance use disorder patient records but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient.
- Violation of the federal law and regulations by a Bowen Center is a crime and that suspected violations may be reported to appropriate authorities consistent with 42 CFR Part §2.4, along with contact information;
- Information related to a patient's commission of a crime on the premises of the Bowen Center or against personnel of Bowen Center is not protected;
- Suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected;
- Disclosures are permitted without patient consent for Medical Emergencies, research purposes, and audit and evaluation activities;
- Not covered by the regulations in this part: (1) Diagnosis which is made solely for the purpose of providing evidence for use by law enforcement agencies or officials; or (2) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved does not have a substance use disorder (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

Disclosures for Treatment and Health Care Operations

Patient consent is required for disclosures of your records for payment or health care operations activities; a lawful holder who receives such records under the terms of the written consent may further disclose those records as may be necessary for its contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of such lawful holder. In accordance with 42 CFR Part §2.13(a), disclosures under this section must be limited to that information which is necessary to carry out the stated purpose of the disclosure. Refer to 42 CFR Part §2.33 for a list of examples of permissible payment or health care operations activities under this section.

I consent for Bowen Center to disclose my substance use records for use in payment and healthcare operation activities as described under 42 CFR Part §2.31 and §2.33. I understand that this consent does not expire unless I submit, in writing, my request to revoke my consent.

_____ _____

Patient Name Patient Signature Date

Financial / Nominal Fee Assessment

Please answer the following questions:

1. Do you currently have active Medicaid? ☐ No ☐ Yes

   (Having Medicaid or Medicare will not be used to determine eligibility for fee assistance discounts.)

2. Size of family unit: _____ (*Number of individuals supported by the family income: Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Bowen Center will also accept non-related household members when calculating family size.)*

3. Head of Household Name:_____

4. Total annual household income Salary: $ _____

5. Below are the current federal poverty guidelines:

   Income includes gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; public assistance; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

Household Size	200% of Federal Poverty Guidelines
1	$27,180
2	$36,620
3	$46,060
4	$55,500
5	$64,940
6	$74,380
7	$83,820
8	$93,260
	Add $9,440 for each additional person

☐ I certify I have no income.

****Supporting documentation of income is requested but not required to be eligible for the Sliding Fee Discount if you are uninsured****

My signature certifies that the total gross household income is accurate.

_____ _____

Patient or Parent/Guardian Signature Date

Medical Problems / Health Status

Check below all current or historic medical conditions:

☐ You are at risk for sexually transmitted diseases ☐ High Cholesterol ☐ Obesity ☐ Dental Problems
☐ Birth Defects ☐ Diabetes ☐ Heart Conditions ☐Asthma ☐ Ear Infections ☐Severe Acne ☐ Eczema
☐ Hypertension ☐ Kidney Issues ☐ Liver Issues ☐ Seizures ☐ Head Injury ☐ Positive TB Test
☐ Shunt ☐ Tuberculosis (symptoms may include chronic cough, night sweats, fatigue, or weight loss)
☐ Medical problem:_____ Treating Physician:_____
_____ _____
_____ _____
_____ _____

☐ Has not had a physical examination within the past one year Date of last exam:_____
☐ Immunizations are not current (including flu vaccine) Why?_____
☐ Medical equipment used (Ex: prosthetic, pacemaker, walker, VNS, etc.) List:_____
☐ Do you have any hearing, vision, or speech problems? Describe:_____

Were any items checked above? ☐No ☐Yes

Staff Use Only:

***** If "Yes" is checked above, recommend that the client see a physician for a physical examination and treatment of the identified condition. Include analysis of the impact the physical condition has on his/her mental health. *****

Is there any family history of medical problems? If ***yes***, please describe.	☐No ☐Yes
Have you been injured in the past year (address falls, broken bones, sports injuries, etc.)? If ***yes***, describe:	☐No ☐Yes
Do you have any allergies? ***If yes***, list:	☐No ☐Yes
If female, are you currently pregnant, or breast feeding? Due date:	☐No ☐Yes

Pain/Discomfort Evaluation

Do you have any present or recurring physical pain/discomfort? ***If yes****, please circle/select a number on the scale below that describes your pain.*	☐No ☐Yes

No Pain — Distressing Pain — Unbearable Pain

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Where does it hurt? When did the problem start? How long does it last?

Are you already receiving treatment for the identified pain? ***If yes***, name physician:	☐No ☐Yes
What activities are you unable to do because of pain?	

Nutrition Risk Screening

Do you have any of the following medical conditions? ☐ Heart disease ☐ Kidney disease ☐ Cancer ☐ Diabetes ☐ Frequent choking ☐ Difficulty swallowing or chewing ☐ Obesity	☐No ☐Yes
After eating, do you experience digestive problems? *If yes,* specify: ☐ Diarrhea ☐ Vomiting ☐ Heartburn ☐Stomach pain ☐ Other (please describe):	☐No ☐Yes
Are you using drugs or alcohol excessively and not eating?	☐No ☐Yes
Do you have an eating disorder? *If yes,* specify: ☐ Anorexia ☐ Bulimia ☐ Overeating	☐No ☐Yes
Have you unintentionally gained or lost 5 lbs in the past month?	☐No ☐Yes
Has your physician prescribed a modified diet? *If yes,* specify:	☐No ☐Yes
Are you allergic to foods? *If yes,* specify:	☐No ☐Yes
Are you unable to buy or cook your food?	☐No ☐Yes

***** If there is a "Yes" response to any of the above nutritional risks, recommend a referral. *****

Medication

Are you taking prescription medication(s)? ***If yes,*** complete the attached medication list.	☐No ☐Yes
Provide any other medical information that would be important to your care:	

_____ _____
Client Signature Date

Client Name _____
MRN _____
Service Location _____

ADMISSION MEDICATION LIST

CLIENT: Please list medications prescribed by physician. **Date:**

Medication	Prescriber	Medication	Prescriber

Do you take herbal medication(s)? ☐No ☐Yes *If yes,* please list:	

Do you take non-prescription (over-the-counter) medication(s) more than twice a week? ☐No ☐Yes *If yes,* please list:	

Client Signature_____

Medication list verified by Nurse: ***To be completed only within 180 days from date above.***

Date	Medication/Dose	Med Ed	Prescriber	Verified	Nurse Signature

C554 (06/12/09)
(Tab:P/O)

Admission Medication List
Bowen Center

Client Name_____
MRN_____
Service Location_____

Bowen Center
Authorization for Communication via Text

Bowen Center recognizes the need to protect the privacy of your Protected Health Information (PHI). It is important that you understand texting is not a secure mode of communication.

If you choose to participate in text communication with Bowen Center, please note:

- Because text communications are not secure, they should contain limited information.
- For your protection, do not send personal identifiers via text messages, such as your last name, age, birth date, social security number, etc.
- Staff response to text message will not contain any protected health information.
- Texting should not be used as a means to reach staff after regular hours, on the weekends, or when staff is on leave. (This may be different for Care Navigation Clients)
- In the case of an after hours emergency, please call the Bowen Center main line at (574) 267-7169 or dial 911.

By signing below, I give Bowen Center permission to communicate with me via text. I am aware that texting is not secure, and that the confidentiality of the texts I send cannot be guaranteed. I understand and agree to the terms listed above.

_____ _____

Client/Parent/Guardian Signature Date

_____

Printed Client/Parent/Guardian Name