

**VALLE VISTA HEALTH SYSTEM - CLIENT INFORMATION SHEET**  
**PATIENT INFORMATION - PLEASE PRINT LEGIBLY**

Name (Last, First, Middle, Maiden)			Previous Name Used (Previous Admission)		
Street Address		City	State	Zip Code	Phone # (area code) ( )
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	Age	Birthplace	Social Security Number	
Marital Status <input type="checkbox"/> Life Partner <input type="checkbox"/> Unknown <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Separated			Ethnic Origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Multi-Racial		
Religion Preference	Education	How did you find out about us? (Referral Source)			
Family Physician, Address and Phone Number			Previous Treatment at Valle Vista? <input type="checkbox"/> No <input type="checkbox"/> Yes	When?	
Employer			Occupation	Length of Employment	
Street Address		City	State	Zip Code	Phone # (area code) ( )
Legal Guardian Name		Relationship	Home phone # (area code) ( )	Work/cell phone # (area code) ( )	
Street Address		City	State	Zip Code	
Emergency Contact		Relationship		Home phone # (area code) ( )	
Street Address		City	State	Zip Code	Work/cell phone # (area code) ( )

**INSURED PARTY INFORMATION (WHO IS THE INSURANCE POLICY HOLDER)**

Insured's Name	Relationship	Social Security Number	Birth Date	Driver's License #
Street Address		City	State	Zip Code
Phone # (area code) ( )				
Employer	Union Name / Local Number	Occupation	Length of Employment	
Street Address		City	State	Zip Code
Phone # (area code) ( )				
Name of Insurance Company				
By signing below, I authorize Valle Vista Health System to verify my insurance benefits				Date
X				

**DO NOT WRITE BELOW**

Admit by	Admit Date	Admit Time	Legal Status (vol, invol)	Patient Number
Admitting Diagnosis				Medical Record Number
Admitting Physician		Attending Physician		Unit/Program

Valle Vista Health System  
**MEDICAL SCREENING QUESTIONNAIRE**

Name: \_\_\_\_\_

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

Name of Family Physician: \_\_\_\_\_

- |                          |                          |  |
|--------------------------|--------------------------|--|
| YES                      | NO                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Current Physical illness. If yes, please explain: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a temperature in the past 24 hours?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any nausea, vomiting or diarrhea in the past 24 hours?                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a sore throat?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have an IV, heparin lock, subclavian IV?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you need assistance with walking, bathing, or other physical activities? If yes, please list. _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any recent head injuries?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any recent loss of consciousness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever tested positive for tuberculosis?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an active infection of MRSA or VRE?  |

In the last month, have you or your family been exposed to or had:

- |                          |                          |              |                          |                          |   |                          |                          |                  |
|--------------------------|--------------------------|--------------|--------------------------|--------------------------|---|--------------------------|--------------------------|------------------|
| Y                        | N                        |              | Y                        | N                        |   | Y                        | N                        |                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken pox  | <input type="checkbox"/> | <input type="checkbox"/> | Head lice   | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough    |
| <input type="checkbox"/> | <input type="checkbox"/> | Measles      | <input type="checkbox"/> | <input type="checkbox"/> | Scabies   | <input type="checkbox"/> | <input type="checkbox"/> | Spitting Blood   |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps        | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease/<br>Sexually transmitted disease | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Strep throat | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                                      | <input type="checkbox"/> | <input type="checkbox"/> | Night Sweats     |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis    | <input type="checkbox"/> | <input type="checkbox"/> | Previous TB Test? Date _____                      | <input type="checkbox"/> | <input type="checkbox"/> | Weight Loss      |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea     | <input type="checkbox"/> | <input type="checkbox"/> |   | <input type="checkbox"/> | <input type="checkbox"/> | Weakness         |

**If any of the above are checked "YES", please inform RN.**

Unit Staff Member: \_\_\_\_\_ RN was informed of medical concerns from the Screen at (time) \_\_\_\_\_

Signature - Assessment Referral Staff \_\_\_\_\_

Date \_\_\_\_\_

<u>Children/Adolescents Only</u>	Yes	No	Date/Age/Describe:			
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>				
Mumps	<input type="checkbox"/>	<input type="checkbox"/>				
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>				
Rubella	<input type="checkbox"/>	<input type="checkbox"/>				
Rubeola	<input type="checkbox"/>	<input type="checkbox"/>				
Immunizations are Current	<input type="checkbox"/>	<input type="checkbox"/>	(Youth only)			
DTP and/or Tetanus	1__ 2__ 3__ 4__ 5__		Rubella (German Measles)	1__ 2__		
Oral Polio	1__ 2__ 3__ 4__		Mumps	1__ 2__		
Measles	1__ 2__		Hib	1__ 2__ 3__ 4__		
<input type="checkbox"/> Parent indicates immunizations are up to date but dates are unavailable. <input type="checkbox"/> Parent indicates immunizations are not up to date, instructed to follow up with physician after discharge. Education Release of Information Consent Form Signed: <input type="checkbox"/> Yes <input type="checkbox"/> No (Youth only)						
PLEASE OBTAIN COPY OF IMMUNIZATIONS IF AVAILABLE.						

**Nursing Home Clients:**

- PPD Skin Test/chest x-ray in the last seven days?  
 If no, instruct nursing home to complete.  
 If yes, results \_\_\_\_\_
- Patient has indwelling catheter and /or any open wounds?  
 If yes, request a MRSA and a VRE culture:  
 Results: \_\_\_\_\_

If active TB or MRSA/VRE, please notify MD and arrange for appropriate medical care.

VALLE VISTA HEALTH SYSTEM  
YOUTH DEVELOPMENTAL ASSESSMENT

Patient Name: \_\_\_\_\_

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

**PRENATAL**

Mother's Activities During Pregnancy

Smoking  Yes  No  
Alcohol  Yes  No  
Drugs  Yes  No  
Prescription Medication  Yes  No  
Full Term Pregnancy  Yes  No  
Prenatal Complications  Yes  No

Describe:

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

**PERINATAL**

Length of Labor \_\_\_\_\_ Normal Vaginal  Yes  No    Cesarean  Yes  No  
Labor Induced  Yes  No    Forceps  Yes  No    Vacuum  Yes  No

**NEONATAL**

Birthweight \_\_\_\_\_ Inches \_\_\_\_\_  
Required Oxygen at Birth  Yes  No  
Jaundiced at Birth  Yes  No  
Bilirubin Lamp  Yes  No  
Child Went Home with Mother  Yes  No

Describe:

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

**DEVELOPMENT MILESTONES**

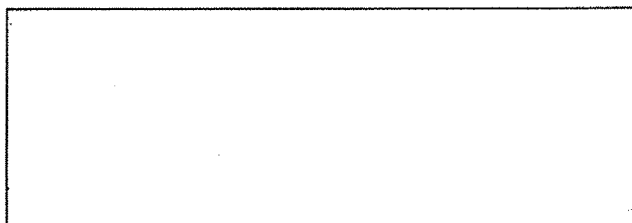
Child's Age When Activities Began?

Talking \_\_\_\_\_ Holding Ball or Stuffed Toy \_\_\_\_\_ Toilet Training \_\_\_\_\_  
Walking \_\_\_\_\_ Feeding Self \_\_\_\_\_ Hold a Utensil \_\_\_\_\_  
Any Mannerisms or Stereotypical Movements?  Yes  No

List: \_\_\_\_\_

Informant: \_\_\_\_\_

Relationship: \_\_\_\_\_





**AUTHORIZATION FOR USE OR RELEASE OF INFORMATION  
COMPREHENSIVE**

**FOR THE RECIPIENT OF THE INFORMATION:**

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I, \_\_\_\_\_  
(Name of Patient) (Date of Birth)  
\_\_\_\_\_  
(Address)

hereby authorize Valle Vista Health System to use or release specified confidential medical, psychiatric (including alcohol and/or drug), HIV/AIDS test results or diagnoses, and/or educational information obtained in the diagnosis and treatment at the hospital to the below indicated persons/agencies and for the stated reasons. I understand that this authorization extends to all or any part of the records/information, and I understand that Valle Vista Health System will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

**Please check Yes, No or Not applicable for each category listed.**

**REFERRAL SOURCE**       Yes     No     Not applicable      Initial if Yes \_\_\_\_\_

\_\_\_\_\_  
(Name and Address)

**Purpose:** To aid in the success of treatment, to provide continuity of care.

**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluation, Admission Assessment; Continuing Care/Discharge Plan, Discharge Summaries, Aftercare Plan

**EMPLOYER**       Yes     No     Not applicable      Initial if Yes \_\_\_\_\_

\_\_\_\_\_  
(Employer Name and Address)

**Purpose:** For verification of admission and stay in the hospital and/or insurance coverage benefits.

**Information to Use or Release:** Admission/Discharge Notification, Admitting Diagnosis, FMLA forms

**FAMILY PHYSICIAN**       Yes     No     Not applicable      Initial if Yes \_\_\_\_\_

\_\_\_\_\_  
(Name and Address)

**Purpose:** To aid in the success of treatment, to provide continuity of care.

**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluations, Discharge Summaries, Aftercare Plan, Laboratory results

Name of Patient: \_\_\_\_\_

**EAP OR LEGAL**                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

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**(Name and Address)**

**Purpose:** To aid in the success of treatment, to provide continuity of care

**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluation, Admission Assessment; Continuing Care/Discharge Plan, Discharge Summaries, Aftercare Plan

**CLERGY**                                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

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**(Name and Address)**

**Purpose:** To visit with Patient.

**Information to Use or Release:** Verbal Communication with patient only.

**FAMILY MEMBER**                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

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**(Name, Relationship and Address)**

**Purpose:** To aid in the success of treatment.

**Information to Use or Release:** Admission/Discharge Notification, progress reports, discharge planning, family counseling

**EMERGENCY CONTACT**                       Yes     Refused                      Initial if Yes \_\_\_\_\_

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**(Name, Relationship, Telephone Number)**

**Purpose:** To notify emergency contact the status of patient if deemed necessary by physician.

**Information to Use or Release:** Patient hospitalization, progress reports

**VISITATION SUPPORT PERSON**     Yes     Declined                      Initial if Yes \_\_\_\_\_

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**(Name, Relationship and Address)**

**Purpose:** To exercise patient's visitation rights in the event patient is unable to do so.

**Information to Use or Release:** Knowledge of patient's hospitalization

**OTHER**                                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

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**(Name and Address)**

**Purpose:** To aid in the success of treatment, to provide continuity of care

**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluation, Admission Assessment; Continuing Care/Discharge Plan, Discharge Summaries, Aftercare Plan

**OTHER**                                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

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**(Name and Address)**

**Purpose:** To aid in the success of treatment, to provide continuity of care

**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluation, Admission Assessment; Continuing Care/Discharge Plan, Discharge Summaries, Aftercare Plan

Name of Patient: \_\_\_\_\_

The treatment dates covered by this authorization are from preadmission to discharge and claims resolution. This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Valle Vista Health System from all liability that may arise from the use or disclosure of medical records in reliance on this authorization. **If patient is a minor, relevant state law should be followed with respect to the required signators.**

If requested information may be faxed.  Yes  No Initial if Yes \_\_\_\_\_

1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire upon occurrence of the following event or condition. If none are checked, the authorization will expire 180 days past date of signature.  
 180 days past termination of services at Valle Vista Health System from the date this authorization is signed or  
 at the happening of the following event or date (less than 180 days from date signed):  
\_\_\_\_\_
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign this authorization and that Valle Vista Health System will not condition treatment on whether I sign this authorization.
4. **Certification:** I certify that I am (check whichever applies):  
 The patient, and the identification that I have provided is true and correct.  
 The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of:  
\_\_\_\_\_”.
5. **Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
6. **Copy:** I understand that I will receive a copy of this completed form.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent/Guardian/Personal Representative Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)

(INTERNAL USE ONLY)

I have received \_\_\_\_\_ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(Printed Name)



**EDUCATION AUTHORIZATION FOR RECEIPT, USE OR RELEASE OF INFORMATION**

**FOR THE RECIPIENT OF THE INFORMATION:**

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize:      Valle Vista Health System  
   898 East Main Street, Greenwood, IN 46143  
   317-887-1348

To receive, use or release health information and records obtained during the course of treatment of:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Patient's Phone: \_\_\_\_\_  
Grade Level: \_\_\_\_\_

1. The information is to be received from or used or disclosed to the following school:

**Home  
School**

School/Individual: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

2. Purpose: The purpose of the receipt, use or disclosure is:  
As needed for guidance and educational planning during treatment and upon return to school;  
To determine immunization status of patient.

3. Information to be used or disclosed.  
The information to be used or disclosed includes only those items indicated below, with respect to services provided on or around (insert dates of service): \_\_\_\_\_. If this line is left blank, the treatment dates covered by this authorization are from preadmission to discharge.

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

Immunization Records  
Teacher/Counselor Observations and Ratings  
Principal Disciplinary Reports  
School Permanent Record  
Individual Educational Plans  
Psychoeducational test results

Physician Discharge Summary (from Valle Vista Health System)  
Educational Discharge Summary (from Valle Vista Health System)  
Continuing Care/Discharge Planning Form (from Valle Vista Health System)  
Verbal communications

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Valle Vista Health System from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

If requested information may be faxed.  Yes  No Initial if Yes \_\_\_\_\_

If patient is a minor, relevant state law should be followed with respect to the required signators. Valle Vista Health System will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire upon occurrence of the following event or condition. If none are checked, the authorization will expire 180 days past date of signature.  
 180 days past termination of services at Valle Vista Health System from the date this authorization is signed or  
 at the happening of the following event or date (less than 180 days from date signed):  
\_\_\_\_\_
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign this authorization and that Valle Vista Health System will not condition treatment on whether I sign this authorization.
4. **Certification:** I certify that I am (check whichever applies):  
 The patient, and the identification that I have provided is true and correct.  
 The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of:  
\_\_\_\_\_
5. **Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
6. **Copy:** I understand that I will receive a copy of this completed form.

\_\_\_\_\_  
(Date) Patient Signature (Date) (Parent/Guardian Signature)

\_\_\_\_\_  
(Date) Staff Member/Witness Signature (Print Last Name)

\_\_\_\_\_  
(INTERNAL USE ONLY)

I have received \_\_\_\_\_ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

\_\_\_\_\_  
(Date) (Employee Signature) (Printed Name)



**PLEASE NOTE:**  
 Patients attending Valle Vista's school program receive high school credits from Greenwood Community Schools.

**AUTHORIZATION FOR RECEIPT, USE OR RELEASE OF INFORMATION**

**FOR THE RECIPIENT OF THE INFORMATION:**  
 If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize: Valle Vista Health System  
 898 East Main Street, Greenwood, IN 46143  
 317-887-1348

To receive, use or release health information and records obtained during the course of treatment of:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Patient's Phone: \_\_\_\_\_

1. The information is to be received from or used or disclosed to the following school(s):

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Greenwood High School<br>615 W Smith Valley Rd<br>Greenwood, IN 46143<br>317-889-4000<br>Fax: 317-889-4039 | <input type="checkbox"/> Greenwood Middle School<br>523 S Madison Ave.<br>Greenwood, IN 46142<br>317-889-4047<br>Fax: 317-889-4044 | <input type="checkbox"/> Isom Elementary School<br>50 E. Broadway<br>Greenwood, IN 46143<br>317-889-4070<br>Fax: 317-889-4115 | <input type="checkbox"/> Special Services<br>Johnson Co. Schools<br>500 Earlywood Dr.<br>Franklin, IN 46131<br>317-736-8495<br>Fax: 317-738-7226 |
|---|--|---|--|

2. Purpose: The purpose of the receipt, use or disclosure is:  
 At the request of the patient and  
 Other –school enrollment and educational needs

3. Information to be used or disclosed.  
 The information to be used or disclosed includes only those items indicated below, with respect to services provided on or around (insert dates of service): \_\_\_\_\_. If this line is left blank, the treatment dates covered by this authorization are from preadmission to discharge.

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Discharge Summary (if requested) | _____ History and Physical Exam                                    |
| _____ Psychiatric Evaluation   | _____ Psychological Testing  |
| _____ Treatment Plans  | _____ Progress Notes   |
| _____ Laboratory Data and PPD  | _____ X-ray Report   |
| _____ Consultation Reports   | _____ Medication Records   |
| _____ Assessments  | <input checked="" type="checkbox"/> Continuing Care/Discharge Plan |
| _____ Billing/Financial Records                                      | <input checked="" type="checkbox"/> Educational records            |

\_\_\_\_ Letter with date and physician name  
\_\_\_\_ Letter with date, physician name, and diagnosis

X  Educational Case Conferences

Patient Name \_\_\_\_\_  
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This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Valle Vista Health System from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

If requested information may be faxed.     Yes  No                      Initial if Yes \_\_\_\_\_

If patient is a minor, relevant state law should be followed with respect to the required signators. Valle Vista Health System will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

1.    **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire upon occurrence of the following event or condition. If none are checked, the authorization will expire 180 days past date of signature.  
 180 days past termination of services at Valle Vista Health System from the date this authorization is signed or  
 at the happening of the following event or date (less than 180 days from date signed):
2.    **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
3.    **Refusal to sign:** I understand that I may refuse to sign this authorization and that Valle Vista Health System will not condition treatment on whether I sign this authorization.
4.    **Certification:** I certify that I am (check whichever applies):  
 The patient, and the identification that I have provided is true and correct.  
 The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: \_\_\_\_\_
5.    **Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
6.    **Copy:** I understand that I will receive a copy of this completed form.

_____ (Date)	_____ Patient Signature	_____ (Date)	_____ (Parent/Guardian Signature)
_____ (Date)	_____ Staff Member/Witness Signature	_____ (Print Last Name)	

(INTERNAL USE ONLY)

I have received \_\_\_\_\_ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

\_\_\_\_\_  
(Date)                      (Employee Signature)                      (Printed Name)

# VALLE VISTA HEALTH SYSTEM

898 EAST MAIN STREET / GREENWOOD, INDIANA 46143 / (317) 887-1348

## INSURANCE/FINANCIAL CONSENT FOR RELEASE OF INFORMATION

I, \_\_\_\_\_  
(Name of Patient) \_\_\_\_\_ (Date of Birth)  
\_\_\_\_\_  
(Address)

hereby grant Valle Vista Health System permission to contact my insurance company(ies) for my benefits and to provide the necessary information, written and/or verbal, for payment of my claim. This authorization also allows the release of information to any third party payors or representatives providing coverage for this admission and allows the release of information for the purpose of obtaining pre-authorization for treatment and concurrent review.

I also authorize and request you to pay directly to Valle Vista Health System the amount due me in my pending claim for basic medical, major medical and/or surgical treatment or services, by reason of such treatment or services rendered.

\_\_\_\_\_  
(Insurance Company and Certificate Number)

\_\_\_\_\_  
(Insurance Company and Certificate Number)

This information may not be further disclosed or used for any other purpose other than as stated in this authorization. It is further understood that I may have been advised by Valle Vista Health System that I have the right to revoke this consent except to the extent that action has been taken in reliance thereon, and if not earlier revoked, it shall terminate when benefits due have been collected without express revocation.

### NOTICE TO RECIPIENT: PROHIBITION OF REDISCLOSURE

If any of the requested information/records contain information relating to alcohol and/or drug abuse treatment records, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

### FINANCIAL INFORMATION VERIFICATION

I, (as indicated above) hereby authorize Valle Vista Health System to verify all financial information related to admission to the hospital, through the use of Equifax Healthcare Solutions.

Equifax, as a policy, does not post medical inquiries made at the point of registration on your credit report. If you request a copy of your own credit report from Equifax, you, by right, will see all medical facilities who have requested a copy of your credit report. Yet, these inquiries will not be visible to any company pulling your report for any company pulling your report for any purpose.

### NON-COVERED CHARGES BILLING:

It is the policy of Valle Vista Health System to bill patients charges which are not covered by insurance. The most common non-covered charges result from insurance deductibles, non-insured portions and miscellaneous personal items.

After the final insurance payments have been received, a final bill will be sent reflecting the amounts due where applicable. Credit balances will be refunded after final insurance payments have been posted by the hospital.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Staff Member/Witness Signature

\_\_\_\_\_  
(Print Last Name)

**Valle Vista Health System  
Residential Treatment Center - Consents and Acknowledgments**

Patient Name: \_\_\_\_\_

**CONSENT FOR RELIGIOUS SERVICES**

The program of the Residential Treatment Center is multi-disciplinary. In other words, the program integrates a variety of treatment approaches to meet the needs of the children and adolescents served by the program.

Religious services are available to each child and adolescent if he or she desires to participate in them. Although not affiliated with any particular denomination, these services are Christian. They include but are not limited to worship services on Sunday morning, traditional Sunday school, and individual pastoral counseling. Those professionals providing religious services recognize that spirituality has a variety of expressions. As a result, they are sensitive to this diversity, and encourage spiritual expressions, which contribute to the overall mental health of the patients served.

Consent:       Yes       No

**CONSENT TO PARTICIPATE IN CLASSES ABOUT HUMAN SEXUALITY**

The Residential Treatment Center (RTC) Program recognizes that emotionally disturbed and/or chemically dependent adolescents are vulnerable to sexual exploitation and/or precocious sexual activity. We believe that by providing adolescents with information about human sexuality appropriate to their age and by encouraging them to discuss that information in a group format, they will be better prepared to act appropriately upon discharge.

Consent:       Yes       No

**CONSENT FOR TUBERCULIN SKIN TEST**

A TB skin test will be administered upon admission and annually thereafter if still a patient at Valle Vista Health System. I acknowledge that he/she has not tested positively previously to a TB skin test or has not been treated for TB.

Consent:       Yes       No

**CONSENT FOR IMMUNIZATIONS**

Patients will receive immunizations and updates as recommended by the Indiana State Department of Health in order to meet compliance requirements. I understand that immunizations will be updated, if required, according to the immunization records that have been provided to Valle Vista Health System and will be administered by our nursing staff or at the Health Department.

Consent:       Yes       No

**COMMUNICABLE DISEASE ACKNOWLEDGMENT**

I acknowledge that the above named patient has not been exposed to any communicable diseases within the past three (3) weeks prior to his/her admission to Valle Vista Health System.

Yes       No

**ACKNOWLEDGEMNT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge receipt of Valle Vista Health System's Notice of Privacy Practices. (Document is on file at the county office designated in the Individual Child Placement Agreement of Indiana Department of Children Services.)

Yes       No

**ACKNOWLEDGEMNT OF RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES**

I acknowledge receipt of Valle Vista Health System's RTC Patient Rights and Responsibilities. (Document is on file at the county office designated in the Individual Child Placement Agreement of Indiana Department of Children Services.)

Yes       No

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

Valle Vista Health System  
Visitation and Phone List

Patient Name: \_\_\_\_\_ Medical Record # \_\_\_\_\_

Visitation Support Person:

Name	Relationship to Patient
_____	_____

Visitation List for **immediate** family members:

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

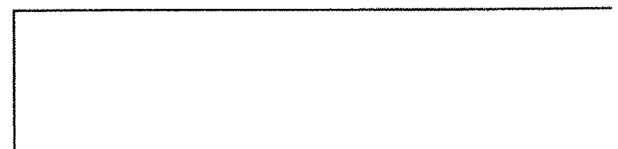
Visitation List for **other involved parties** (i.e. CASA, probation, clergy, etc.) (Should be included on Release of Information form)

Name	Relationship to Patient	ROI Obtained
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>

Phone List for **immediate family** members:

Name	Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

(A valid Authorization for Release of Information form must be obtained prior to releasing any patient information, verbal or written.)





FAMILY THERAPY CONTRACT  
RESIDENTIAL TREATMENT CENTER

To fulfill my commitment to the treatment of my child, I agree to participate in Family Therapy. **This will usually take place during regular business hours with the therapist assigned to my child.**

Family therapy sessions are usually conducted twice per month. There will be times when family therapy will occur more than twice per month as appropriate. My child's therapist will contact me to schedule the first family therapy session shortly after my child is admitted. It will be important for me to schedule all future sessions with the therapist on a monthly basis in order to avoid disruption of the treatment process. If at anytime I am unable to keep my scheduled appointment, I will contact the therapist at least 24 hours in advance to that another appointment can be scheduled

Daytime telephone number: \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



**Valle Vista Health System  
Philosophy and Practice for Seclusion & Restraint Use  
RESIDENTIAL TREATMENT CENTER**

**WHAT IS THE PHILOSOPHY OF THE RESIDENTIAL TREATMENT CENTER REGARDING SECLUSION & RESTRAINT USE?**

Valle Vista Health System promotes the use of non-physical interventions and seclusion/restraint is used as the last resort to support the safety of the patient and/or others. The facility is committed to prevent, reduce and eliminate the use of seclusion/restraint through early identifications of high-risk behaviors or events. The dignity and privacy of patients will be preserved to the greatest extent during the implementation and monitoring of these interventions.

**WHAT IS SECLUSION AND RESTRAINT AND WHEN ARE THEY USED?**

Seclusion is any involuntary confinement of a patient alone in a room or area where he/she is physically prevented from leaving or the perception is given to the patient that he/she is unable to leave the room.

Restraint is a hold that involuntarily restricts a patient's freedom of movement, activity or normal access to one's body.

Seclusion or restraint is used when it has been determined that it will be the least restrictive intervention that will be effective to provide immediate physical safety of the patient, a staff member, or others and it is discontinued at the earliest possible time. They require a physician's order and are **never** used as a form of discipline, punishment or convenience for the staff.

**WHAT ALTERNATIVES ARE TRIED BEFORE USING SECLUSION OR RESTRAINT?**

Staff use a variety of alternatives to try and avoid the use of seclusion/restraint. These options may include:

- Giving the patient clear instructions and directions about his/her behavior.
- Encouraging the patient to talk about what's making him/her angry and/or frustrated.
- Reducing negative stimuli in the patient's environment e.g. loud noises, turning out lights, allowing the patient alone time.
- Offering diversionary and physical activities e.g. music, exercise, reading.
- Providing medications that the physician has ordered to help the patient to relax/gain control of his/her emotions.
- Using information provided by the patient and/or family regarding what calms him/her.

**WHAT BEHAVIORS WILL RESULT IN RELEASE FROM SECLUSION/RESTRAINT?**

Patients are released from seclusion/restraint when they demonstrate behavioral control, show improved ability to understand and follow directions and are no longer dangerous to themselves, other patients and/or staff.

**HOW CAN YOU HELP?**

If you are aware of events in the past that you think may assist with these behaviors, or if you are aware of methods that have been used in the past that were helpful, please inform the staff. To the extent that it is possible, we will incorporate this information into the treatment plan.

- If a seclusion/restraint intervention is used during your hospital stay, who would you want to be notified?

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

- I do not want anyone to be notified.

The parent/guardian will be notified when seclusion/restraint is used and the reason for this intervention  
in all cases with minors (patient younger than 18 years of age)

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

STAFF SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_