A New Crossroad
P:864-295-1280
Email: anewcrossroad@gmail.com

Have you previously been a client of A New Crossroad? Yes ____ No ____ Date: ______________________

How did you hear about us: Friend: _____ Google Search: _____ Other: ____

Client Name: ____
(Last) (First) (Middle) (Age)

Client Address: ____
(Street) (City) (State) (Zip)

Sex ______________ Date of Birth: ______________________ DL# ____

Phone#: ____________________ Alt: ______________________ Email: _________________________________

Contact Person: ____________________________________ Relationship: ______________________________

***Emergency Telephone # (include area code) (   ) ____

Primary Insurance: ______________________________ ID# ____________________ Group# ____________________

Name of Insured if different from Patient: _____________________________________ DOB: ________________

Are you currently a student? ____________ If yes, full-time or part-time/Where _____________________________

Marital Status: _____________ Spouse Name: ____

Reasons seeking treatment: *Is Problem Drug Related? Yes* _____ *No* _____ Brief description: ____________________

____

Have you experienced traumas or significant loss in your life? Yes ___ No ___ List: ________________________

____

A NEW CROSSROAD

For females: Are you currently pregnant? Yes ___ No ___ Unsure? ___

Do you have any allergies? Yes ______ No ______ List: ____

Do you have any known adverse drug reactions?: Yes ______ No ______ List: _________________________________

Current medications: ____

____

Primary Care Physician (PCP): ____

Preffered Pharmacy: ____

A New Crossroad
P:864-295-1280
Email: anewcrossroad@gmail.com

Authorization to Contact Client

We are required by HIPAA and other federal laws to obtain your written permission before we can contact you. We may contact you or your emergency contact for emergency and non-emergency reasons including confirming appointments, follow-ups, test results and financial reasons. The information you provide will be kept confidential and only used for the purpose of contacting you and in the ways listed below.
I do hereby authorize the staff of ANC to also contact me at the below listed phone number(s), in the following ways, in regards to appointments/services. Phone Number(s): ________________________ ________________________

☐Home Phone ☐ Cell Phone ☐ Emergency Contacts ☐ Email ☐ Postal Service ☐ May we leave a message

Consent for Telemedicine Services

Introduction:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or sub-specialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Interactive audio and video and/or data communications.
- Output data from medical devices and sound and video files.

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

A NEW CROSSROAD

Potential Benefits:

- Improved access to medical care by enabling a patient to remain in his/her Providers office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

· In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
· Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
· In exceedingly rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
· In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.
6. I understand that it is my duty to inform my ophthalmologist of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding treatment services and telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize ANC to use telemedicine in the course of my diagnosis and treatment. In addition, I have answered all questions truthfully and I fully understand the consequences of deception/omission and violating these policies.

Signature of Client: ______________________________________ Date: _____________

For substance abuse clients: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and in any case, this consent expires automatically as follows: ***1 year following the date of discharge.***

A NEW
CROSSROAD