



State of South Carolina

Department of Mental Health

MENTAL HEALTH COMMISSION:

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Kenneth Rogers, MD

Berkeley Community Mental Health Center

P.O. Box 1030
Moncks Corner, SC 29461
Information: (843) 761-8282
J. Matthew Dorman, Executive Director

Thank you for choosing Berkeley Community Mental Health Center for your mental health needs.

Due to our current operations under COVID 19 we have had to modify our Intake procedures. Instead of us meeting with you face to face to complete this paperwork we are asking you to complete and return it to the email address below.

Go to www.berkeyleymentalhealth.org and choose Intake Packet and complete and email to tabitha.pressley@scdmh.org. Please note that this email address is not monitored.

In addition to the forms please send in copy of all your insurance card(s), proof of household income, and your identification such as driver's license, as applicable.

If any questions please call us at 843.761.8282.

Thank you.

PLEASE BE AWARE THAT THIS EMAIL ADDRESS IS NOT MONITORED.

IF YOU ARE EXPERIENCING A PSYCHIATRIC (MENTAL HEALTH) CRISIS, PLEASE CALL OUR MOBILE CRISIS/COMMUNITY CRISIS RESPONSE AND INTERVENTION TEAM, TOLL-FREE, AT (833) 364-2274. IT IS AVAILABLE AT ALL TIMES.

AS ALWAYS, IF YOU ARE EXPERIENCING A MEDICAL EMERGENCY, PLEASE CALL 911.

MISSION STATEMENT

To support the recovery of people with mental illnesses.

**EXHIBIT # UN-53
COMMUNITY MENTAL HEALTH CENTER
DETERMINATION OF ABILITY TO PAY REDUCTION**

Client _____ CID _____ Guarantor of payment if other than client _____
 SS#: _____ Date of Birth: _____ Prepared by: _____
 Address: _____ Telephone #: _____

INCOME	CURRENT	UPDATE	EXTRAORDINARY EXPENSE	CURRENT	UPDATE
Self	\$	\$	Medical	\$	\$
Spouse/ Household	\$	\$	Alimony/Child Support	\$	\$
Public Assistance (list each type)*	\$	\$	Other Non-Discretionary (list each)***	\$	\$
	\$	\$		\$	\$
Alimony/Child Support	\$	\$		\$	\$
Other (list each)**	\$	\$		\$	\$
	\$	\$		\$	\$
GROSS INCOME:	\$	\$	GROSS EXPENSES:	\$	\$

GROSS INCOME	LESS GROSS EXPENSES	EQUALS ADJUSTED GROSS INCOME	NUMBER IN HOUSHOLD

- * List each type of public assistance, such as food stamps, AFDC, etc.
- ** For other recent income, other liquid assets or funds available for payment of medical bills including bank accounts, assets accumulated from public benefit payments, trust, etc.
- *** For recent non-recurring expenses, medical expenses, etc.

OTHER RESPONSIBLE PARTY **PARENT/GUARDIAN/OTHER**
I do hereby certify that I accept responsibility for all charges for services provided to the above client.

_____ Date: _____ SSN: _____
Responsible Individual's Signature **Responsible Individual's Social Security Number**

I ACKNOWLEDGE THAT THE INFORMATION GIVEN IS ACCURATE AND COMPLETE AND THAT I WILL UPDATE THE INFORMATION AS IT AFFECTS MY ABILITY TO PAY. YOU MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES IF YOU GIVE FALSE OR INCOMPLETE INFORMATION.

I AUTHORIZE ANY ENTITY HOLDING FINANCIAL RECORDS OR OTHER INFORMATION IN ANY FORM PERTAINING TO THE FINANCIAL INFORMATION GIVEN BY ME ABOVE TO DISCLOSE TOT HE CENTER ANY FINANCIAL INFORMATION NECESSARY FOR THE CENTER TO DETERMINE MY ELIGIBILITY, IF ANY, FOR A REDUCTION ON MY BILL.

I have been given a completed copy of this form and understand that I may request a review of my ability to pay at any time. This information may be updated at any time but must be reviewed at least annually.

 Client Signature Date (if applicable) Guarantor

 Client Signature (Update) Date (Updated) Date

IF A US FEDERAL INCOME TAX RETURN HAS NOT BEEN FILED FOR THE PREVIOUS CLAENDAR YEAR AND/OR WILL NOT BE FILED FOR THE CURRENT YEAR, I DO HEARBY SWEAR THAT MY ANNUAL INCOME IS BELOW THE LEGAL LIMIT FOR FILING FOR LAST YEAR AND IS ANTICIPATED TO REMAIN BELOW THE LEGAL LIMITS THIS CURRENT YEAR.

Client Signature

Date

Third party payors:

I do hereby certify that I have no third party capability; therefore I am responsible for all charges for services provided to me.

Client Signature

Date

I do hereby certify that I accept responsibility for all charges provided to the above client

Responsible Individual Signature

Date

Demographic Information

Sex: Race: White African/American Spanish/American Asian/American American Indian Other
Marital Status: Single Married Divorced Widowed Separated Unknown Other
Grade in School: _____
School: _____
Legal Guardian: _____

MEDICAL RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process **Medicare, Medicaid, Champus/VA, or**

Private insurance claims for _____ for services provided to
(Client's Name)
them with a starting date of _____ and request payment of benefits to:
(Admission Date/Update)

***BERKELEY COMMUNITY MENTAL HEALTH CENTER
P.O. BOX 1030
MONCKS CORNER, SC 29461***

Client's Signature (authorized person)
REV: BCMHC 9/06/07

Witness

CONSENT TO EXAMINATIONS AND TREATMENT

Consent and authority is hereby given to this mental health facility and its professional staff to perform or have performed examinations and / or psychotherapy and / or related mental health treatments and to administer medications when deemed necessary or advisable by appropriate members of the professional staff in consultation with me. This statement has been fully explained to me and I understand it.

Witness

Signature of Patient

Date

Signature of Parent or Legal Guardian

I have been provided copies of the SCDMH Notice of Privacy Practices and Client Rights and an opportunity to ask questions:

(If not signed, staff to state reason on line and initial)

Signature

Date

**SIGNIFICANT OTHER PARTICIPANTS INVOLVED
IN THE IDENTIFIED PATIENT'S SERVICES**

I agree to participate in therapy focused on the patient signing above. I understand that any information that I give may be included in the patient's record and disclosed as allowed by law. I also understand that if I want to receive therapy or other treatment services, a separate consent to examination and treatment is required.

Participant / Relationship

Date

Staff Initials

Participant / Relationship

Date

Staff Initials

Participant / Relationship

Date

Staff Initials

Participant / Relationship

Date

Staff Initials

Participant / Relationship

Date

Staff Initials

The staff who obtain the other participant signature above enter initials and signature here.

Staff Initials

Staff Signature

Staff Initials

Staff Signature

Client Orientation Checklist

I have received the following information about the Center via a client handbook, separate brochure, and/or orally, and I have been given the opportunity to ask questions.

- Rights and Responsibilities
- Complaint and appeal procedures
- Ways to give input
- Services and activities; coordination with other agencies
- Expectations; importance of family involvement in treatment
- Hours of operation
- Access to after-hour and emergency services
- Code of Ethics and professional conduct
- Confidentiality Policy
- Requirements for reporting and follow-up if court-ordered to treatment
- Financial obligations, fees, and arrangements
- Familiarization with premises including emergency exits and/or shelters, fire extinguishers, and first aid kits
- Program's health and safety policies regarding:
 - use of seclusion/restraint
 - use of tobacco products
 - illegal and legal drugs
 - prescription medication brought into the program
 - weapons
 - drug screens
- Identification of your primary contact staff person
- Program rules and expectations, including:
 - restrictions
 - events, behaviors, or attitudes leading to loss of privileges
 - means by which rights or privileges that have been restricted can be regained
- Education regarding Advance Directives
- Purpose and process of the assessment and potential course of treatment
- Development of the Plan of Care and your participation including discharge/transition criteria and procedures
- Assistive technology that might be helpful in treatment

Client Signature

Date

CID#

Staff Signature

Date

SOUTH CAROLINA

VOTER REGISTRATION DECLINATION FORM

If you are not registered to vote where you live now, would you like to register to vote here today?

YES

NO

Already registered to vote

Will use registration by mail application.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application from in private.

If you decided to register to vote, that decision will remain confidential and be used only for voter registration purposes.

If you register to vote, information regarding the office in which the application was submitted will remain confidential, again, to be used only for voter registration purposes.

Signature of Declinee/Applicant

Date

If you believe that someone has interfered with your right to register or to decline to vote, your right to privacy in deciding whether to register or in applying to vote, you may file a complaint with the following:

**Executive Director
State Election Commission
P.O. Box 5987
Columbia, S.C. 29250
(803) 734-9060**

Berkeley Community Mental Health Center

CLIENTS WHO ARE COURT ORDERED TO TREATMENT

If you have been court ordered to treatment, this means that the Mental Health Center has a responsibility to work with the Court to ensure that you are in compliance with the order to treatment. We will need to contact the Court to let them know that you have entered treatment and that you are or are not following treatment recommendations. If you should cease your compliance with the order from the Court, we are required to contact the Court with this information. This may result in a supplementary hearing by the Court to decide the next course of action. The Mental Health Center desires a good working relationship with clients who are court ordered to treatment; however, clients should be aware of the requirements of their court order. If records or your counselor are subpoenaed to court information may be released by court order without your permission. All information requested by the judge must be released, but only the specific information requested is released.

I have read and understand the above information.

SIGNATURE

DATE

WITNESS

CLIENT NAME

CID

**BERKELEY COMMUNITY MENTAL HEALTH CENTER
PATIENT EMERGENCY INFORMATION**

In an effort to better serve you, please help us by providing us with the following information.

Patient's Name: _____ Today's Date: _____

Patient's Birth Date: _____ Patient's Social Security Number: _____

Patient's Phone Number(s): Home: _____ Cell: _____ Work: _____

Patient's Physical Address: _____

Patient's Mailing Address: _____
(if different from above)

Patient's Email Address: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Address: _____ Telephone Number(s): _____

I agree for BCMHC to contact the above person for notification of appointments and to leave messages/voice mail concerning appointments. Please initial: _____

ALLERGY INFORMATION: (Please list all known allergies.) _____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed **Race:** _____

Military: _____ Current _____ Past Branch of Military: _____

Family Size: _____ **How many children does the patient have?** _____

Registered Voter? _____ Yes _____ No but _____ Would like to register to vote
_____ Would **Not** like to register to vote

Highest Grade of School Completed: _____

Primary Care Physician (Name, Address and Phone Number): _____

May we contact you by phone, text, and/or email for appointment reminders?

I hereby give Berkeley Community Mental Health Center permission to send appointment reminder messages to me via phone, email and/or text messaging. Please initial: _____

(CHILDREN ONLY) Name of School Attending: _____ Current Grade: _____

Thank you for choosing Berkeley Community Mental Health Center. CID: _____



ELECTRONIC COMMUNICATION CONSENT FORM

As a patient or caregiver of a patient at South Carolina Department of Mental Health (SCDMH), you may wish to communicate with SCDMH staff by email. Your health is important to us and we will make every effort to reasonably comply with your request. We may deny requests for email communications if or when your clinician determines that it would not be in your best interest.

Our office will use reasonable means to protect the privacy of email information sent and received. However, we cannot guarantee the security of email communication. Patients must consent to the use of email for patient information, billing, and communication.

Below are policies outlining when and how email should be utilized to maintain your privacy and to enhance communication, as well as a place for you to acknowledge your consent to its use. Your decision to use email is voluntary and your consent may be withdrawn at any time.

When may I use email to communicate with SCDMH staff?

Email may be used for routine requests. Some examples are:

- Appointment scheduling
- Appointment reminders
- Routine questions
- Referral information
- Requests for medical excuses
- Telehealth links
- Other matters not requiring an immediate response

When should I NOT use email to communicate with SCDMH staff?

Email should never be used:

- In an emergency—use the 24 hour crisis line for emergencies (833-364-2274)
- If you are experiencing any desire to harm yourself or others
- If you are experiencing a severe medication reaction
- To communicate highly sensitive topics
- If you need an immediate response

What are the risks of using email?

Risks of communicating via email include but are not limited to:

- Email may be accidentally sent to an unintended recipient.
- Email may be intercepted by hackers and redistributed.
- Employers/online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email.
- Emails can introduce viruses, malware, or other malicious programs that may damage the computer.
- Email can be used as evidence in court.
- Emails can be intercepted, forwarded, circulated, stored or even changed without the knowledge or permission of either the sender or recipient.
- Copies of an email may continue to exist, even after the email is deleted.

What happens to my messages?

- Emails will be maintained as a permanent part of your medical record.
- As part of your permanent record, they may be released along with the rest of the record upon your authorization or when it is otherwise legally required to do so.
- Messages may be seen by staff for the purpose of filing or carrying out requests (e.g., appointment scheduling).

What are my obligations?

- I must let SCDMH staff know immediately if my email address changes.
- If I do not receive a response within 24 hours, or the timeframe discussed by my clinician, I will contact him/her by telephone if a response is needed.
- I will use email communication only for the purposes stated above.
- I will advise my clinician in writing, should I decide that I would prefer not to continue communicating via email

What steps has SCDMH taken to protect the privacy of my email communications?

- SCDMH email encrypts email messages.
- Every SCDMH computer has a password protected screen-saver.
- SCDMH staff are educated on the appropriate use and protection of email.
- SCDMH staff will not forward patient email to third-parties without your express consent.

What steps can I take to protect my own privacy?

- Do not use your work computer to communicate with SCDMH, as your employer has a right to inspect emails sent through the company’s system.
- Do not use a shared email account to transmit messages.
- Log out of your email account if you will be away from your computer.
- Carefully check the address before hitting “send” to ensure that you are sending your message to the intended receiver.
- Avoid writing or reading emails on a mobile device in a public place.
- Avoid accessing email on a public Wi-Fi hotspot.

Encryption Waiver

SCDMH staff will encrypt all emails sent outside of the SCDMH agency network to protect your privacy. If you are unable to accept encrypted communication for any reason, but still would like to accept emails from SCDMH, you may waive your right to encryption, with the understanding that your information will be less secure.

Please initial here if you prefer NOT to use encryption _____.

CONSENT TO EMAIL USE

By signing below, I consent to the use of email communication between myself and SCDMH. I recognize that there are risks to its use, and despite SCDMH’s best efforts, confidentiality cannot be guaranteed. I understand and accept those risks and the policies for email use outlined in the form. I agree to follow these policies and agree that should I fail do so, SCDMH may cease to allow me to use email to communicate with SCDMH. I also understand that I may withdraw my consent to communicate via email at any time by notifying SCDMH staff in writing.

Name of Patient/Guardian

Date

Signature of Patient/Guardian

Email Address