

Thank you for choosing North Carolina Solutions are your Applied Behavior Analysis provider! It is our goal to help you and your family achieve the results that last a lifetime through high quality services. To ensure the client is receiving the appropriate level of care, a well-trained, Board Certified Behavior Analyst, develops a comprehensive treatment plan. This plan helps build skill level and decrease barriers to learning. Caretakers must comply with all treatment recommendations pertaining to the clients plan to continue to receive services at North Carolina Solutions. This includes keeping all of your appointments as they are scheduled. If recommendations are not followed, you may be referred to another provider. Legal caretakers have the right to access the client's treatment plan upon request.

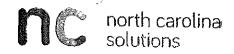
Please provide the front desk with up to date phone number that allows us to leave a message regarding your appointments if needed.

Thank you again for choosing North Carolina Solutions! Do not hesitate to let us know how we are doing.

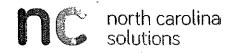
Thank you

Han-Leong Goh, Ph.D, BCBA-D

Executive Director



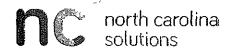
Biogra	aphica!
Child's Name:	Date of Birth:
Caregiver/Legal Guardian #1	
Name:	
Address:	
City, State, Zip:	
Telephone:(Home)	(Work)
(Cell)	
Email:	-
Emergency Contact	
Name:	
Phone:	
Current Medical Providers and School Information	
Name of Primary Care Physician:	
Affiliation:	
Name of Teacher:	
School:	
Referral Source	
Affiliation:	
Sign/Date	
Signature of Client/Parent/Legal Guardian	Date
Signature of NC Solutions Staff	Date



PRIOR PROFESSIONAL CONTACTS

Please list all past and current therapies your child has received by completing each of the boxes below.

Service	Start/End Date (Month/ Year)	How Often?	Length of each therapy session	What goals were being addressed?	Effect of therapy for feeding problem	Therapist Information (Name, address, telephone)
Occupational Therapy		1x/month 2x/month 1x/week	15 min 30 min 45 min		Worse No change Improved	
Yes No		2x/week 3x/week	1 hr 1 5 hrs	, ,		
Physical Therapy ;		1x/month 2x/month 1x/week	15 min 30 min 45 min		Worse No change Improved	
Yes No		2x/week	1 hr 1.5 hrs			
Speech Yes	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	1x/month 2x/month 1x/week	15 min 30 min 45 min		Worse No change Improved	
│	•	2x/week	1 hr 1.5 hrs			
Early Intervention	,	1x/month 2x/month 1x/week	15 min 30 min 45 min		Worse No change Improved	
Yes No		2x/week	1 hr 1.5 hrs			
Others: (please list)		1x/month 2x/month 1x/week 2x/week	15 min 30 min 45 min		☐ Worse ☐ No change ☐ Improved	
		3x/week	1.5 hrs			



MEDICAL INFORMATION

DIL ELI LIISEOLY	
How many weeks pregnant were you when your chi	ld was born?
Was your child born by vaginal delivery or C-section	
What was your child's birth weight/length?	lbsinches
Were there any problems at birth?	
Were there any problems during pregnancy?	
Medical History	
Current Diagnoses:	
At what age did your child receive each diagnosis: _	
Who provided the diagnosis:	
Previous Illnesses:	
Most recent hearing screen:; Re	esults:
Most recent vision screen:; Re	sults:
Past surgeries/hospitalizations:	
History of any of the following? (Check all that apply	
Seizures Diabetes Asth	ma Constipation (frequent)
□ Vision problems □ Hearing Problems □ Sleep	
Describe all checked items above:	5 Hobicins
Describe an checked items above.	
- Annual Control of the Control of t	
Current medications and dosages:	
-	
Food Allergies:	
Are immunizations up-to-date:	
•	
Any foods avoided intentionally by the family?	
Does your child have any health-related restrictions	regarding exercise?
Current height: feet, inches	
Current weight: lbs	
At what age did your child: DEVELOPME	ENTAL HISTORY
Roll over:	Babble:
Sit independently:	Use single words:
Take first steps:	Use short phrases:
Play games (like peek-a-boo):	Use sentences:
Crawl:	Toilet trained during day:
Smile:	Toilet trained at night:

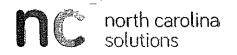


As an infant/toddler, was your of interested in people Overly active Easy to please Irritable/Cranky	hild: Difficult to nurse or feed Interested in toys Underactive Able to be flexible	☐ Difficult to soothe☐ Resistant to touch☐ Reactive to certain noises
	SLEEP SCHEDULE	
Check any that describe your ch	ild.	
Has difficulty going to sleep a Tantrums when put to bed Has other behavior problems Has difficulties going to sleep Has difficulties staying asleep Has difficulties staying in bed Wants to sleep in caregiver's	when put to bed during naps	
My child goes to bed at	pm.	
My child wakes up at		
My child takes a nap from	to	and to
	COMMUNICATION	
What is your child's primary for Gestures Picture Excha How does your child request ite	nge 🗌 Sign Language 🔲 Vo	ocal Language
Does your child (Select Yes or Respond to his/her name? Imitate words/sounds you say?		
Imitate words/sounds from his,	her favorite videos?	Example
Label things that he/she sees? Label things that he/she feels?	Example	
Label things that he/she smells Label things that he/she hears? About how many different thin	Example	
Does your child (Select Yes or		
Follow one step directions? Follow two or more step direct	Example	
Tell you what happened during	Example your child respond? the day? Example_	
How many different words doe	s your child say in a 30-minute	period?



ADAPTIVE SKILLS

Check one that best describes your	child's m	nental abilities.		
☐ Normal Intelligence	☐ Mile	ld ID Moderate ID		
Severe ID	Prof	ofound Intellectual Disability (ID)		
Does your child (Select Yes or No)			
Feed self		Look you in the eye when you are talking		
Dress self		Makes eye contact when pointing		
Help with household chores		Point to things from 3 feet away or more		
Tie shoes		Play with toys the same way		
Walk up/down stairs		Play with a limited number of toys		
Stay near in public places		Play with toys appropriate (hit nails with hammer)		
Imitate things you do		Play with toys imaginatively (use box as phone)		
Talk to peers		Plays with toys next to others		
Does your child have any other be your child's behavior.		ER BEHAVIOR PROBLEMS that you think are a problem? Check any one that describes		
Behavior	Occurs			
Temper tantrums		times perhourdayweekmonth		
Argues		times perhourdayweek month		
Hurts self		times per hour day week month		
Hurts other people		times per hour day week month		
Complains of aches or pains		times per hour day week month		
Throws or breaks things		times per hour day week month		
Makes inappropriate sounds		times per hour day week month		
Attention Deficits		times per hour day week month		
Phobias		times perhour day week month		
Overactive for age		times per hour day week month		
Separation anxiety		times perhourdayweek month		
Doesn't pay attention		times per hour day week month		
Stereotypy (hand-flapping)		times per hour day week month		
Arm/Hand biting		times per hour day week month		
Thumb sucking		times per hour day week month		
Doesn't interact with people		times per hour day week month		
Masturbation		times per hour day week month		
Pica (eats inedible objects)	\Box	tímes per hour day week month		
Insists on routine		times per hour day week month		
Other		times per hour day week month		
What type of supervision does yo Can be left unattended for brie Needs continuous monitoring, Requires 1:1 supervision	f periods	s of time		



OTHER INFORMATION

If your child had an hour to do whatever he/she wanted. Please list which toys, activities, foods, or people he/she would play with:

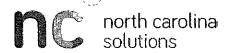
Toys	<u>Foods</u>
1)	1)
2)	2)
·	3)
3)	4)
4)	
5)	6)
6)	
7)	8)
8)	·
9)	3)
Activities	<u>People</u>
Activities	<u>People</u> 1)
1)	
1)	1)
1) 2) 3)	1) 2)
1) 2) 3) 4)	1)
1) 2) 3) 4) 5)	1)
1) 2) 3) 4) 5) 6)	1)
1) 2) 3) 4) 5) 6) 7)	1) 2) 3) 4) 5) 6)
1) 2) 3) 4) 5)	1)

What are your top 3 goals for your child in the next 6 months, rank the priority of the goal, and describe what specifically needs to be addressed.

Priority:

1= not important, 2= somewhat not important, 3= Neutral, 4= somewhat important, 5= very important

Rank (1-3)	Skill	Priority	Describe
	Communication		
	Play Skills		
	Social Skills]	
	Problem Behavior		
	Functional Skills (toileting)		
	Other:		



Child Availability

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 pm					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					

Please indicate how interested you are in learning methods to teach your child new skills.

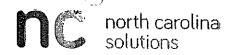
Not at all	Somewhat			Extremely
Interested	Interested	Interested	Very Interested	Interested

Please indicate how many hours each day you and your child are in the same room.

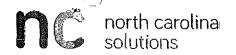
			***************************************	More than 8
0-2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours	hours

Please indicate how many hours each day you practice new skills with your child.

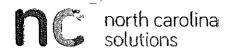
				More than 8
0-2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours	hours



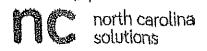
Client Name:	Date of Birth:
FROM (PERSON/AGENCY):	TO (PERSON/AGENCY)
NC SOLUTIONS	Emergency Contact
FROM (PERSON/AGENCY)	TO (PERSON/AGENCY)
Emergency Contact	NC SOLUTIONS
INFORMATION AUTHORIZED FOR RELEASE (CH	ECK ALL THAT APPLY):
Admission/ Evaluation / CCA Medications Labs Treatment Pro Other: Other: CCA Medications CCA Medications Labs Treatment Pro CCA	ogress Testing
INFORMATION: I DOI DO NOT authorize disclosure of recorI DOI DO NOT authorize disclosure of treats. Alcohol and/or drug treatment records are protected under fede and the Health Insurance Portability and Accessibility Act, 45 CFR	ds of alcohol or drug abuse treatment, ment or diagnosis of HIV or AIDS (including test results) ral regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 Parts 160 and 164 These rules prohibit the recipient from making any further disclosure of this the Written consent of the person to whom it pertains or as otherwise permitted by law.
PURPOSE FOR USE OR DISCLOSURE:Personz	al UseTreatmentLegalOther
EXPIRATION: Unless another date, event or codate it is signed. Other date, event, or condition	ndition is listed below, this authorization will expire one (1) year from the
(1) research related, or (2) provided solely for the purpose to provide authorization under the aforementioned circuit purposes. I understand that information disclosed by this authorizations disclosure by the recipient and may no longer be protected and the Privacy Act of 1974 (5 USC 552a) and Client has the	treatment or eligibility for care on my providing this authorization except if such care is of creating Protected Health Information for disclosure to a third party. If Client refuses instances. North Carolina Solutions may refuse to provide care or treatment for these stion, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the resed by the Health insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) he right to revoke this authorization at any time in writing and upon delivery to North and taken in reliance on this authorization, or if applicable, during an insurance
	Date;
Client's Signature	
Signature ofParent/Legal Guardianlf other,	Date:
Witness Signature:	



Client Namer	Date of Birth.
FROM (PERSON/AGENCY):	TO (PERSON/AGENCY)
NC SOLUTIONS	School
FROM (PERSON/AGENCY)	TO (PERSON/AGENCY)
School	NC SOLUTIONS
INFORMATION AUTHORIZED FOR RELEA	ASE (CHECK ALL THAT APPLY):
Admission/ Evaluation /CCAMedia Discharge SummaryLabs Staff NotesTreatr Other:	History/Psychosocial nent ProgressTesting
INFORMATION: I DO I DO NOT authorize disclosure I DO I DO NOT authorize disclosure Alcohol and/or drug freatment records are protected used the Health Insurance Portability and Accessibility A	I OF THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH of records of alcohol or drug abuse treatment. of treatment or diagnosis of HIV or AIDS (Including test results) inder federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 act, 45 CFR Parts 160 and 164. These rules prohibit the recipient from making any further disclosure of this littled by the written consent of the person to whom it perfains or as otherwise permitted by law.
PURPOSE FOR USE OR DISCLOSURE:	Personal UseTreatmentLegalOther
	nt or condition is listed below, this authorization will expire one (1) year from the ondition:
(1) research related, or (2) provided solely for the	ondition treatment or eligibility for care on my providing this authorization except if such care is purpose of creating Protected Health Information for disclosure to a third party. If Client refuses ned circumstances. North Carolina Solutions may refuse to provide care or treatment for these
I understand that information disclosed by this a disclosure by the recipient and may no longer be and the Privacy Act of 1974 (5 USC 552a) and Cli-	nuthorization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the re- protected by the Health Insurance Portability and Accountability Act Privacy Rule (45CFR Part 164 ent has the right to revoke this authorization at any time in writing and upon delivery to North on has been taken in reliance on this authorization, or if applicable, during an insurance is form.
	Date:
Client's Signature	
Client's Signature	



The undersigned hereby authorizes the release	of information from the health record of:
Client Name:	Date of Birth:
FROM (PERSON/AGENCY):	TO (PERSON/AGENCY)
NC SOLUTIONS	Primary Care Physician
FROM (PERSON/AGENCY)	TO (PERSON/AGENCY)
Primary Care Physician	NC SOLUTIONS
INFORMATION AUTHORIZED FOR RELEASE (Ch	HECK ALL THAT APPLY):
Admission/ Evaluation /CCAMedicationsDischarge SummaryLabsStaff NotesTreatment ProOther:	Medical/Physical HistoryHistory/Psychosocial ogressTesting
INFORMATION: I DOI DO NOT authorize disclosure of recording to the protected under federal the Health insurance Portability and Accessibility Act, 45 CFI information unless further disclosure is expressly permitted by the protected under federal the Health insurance Portability and Accessibility Act, 45 CFI information unless further disclosure is expressly permitted by the protection of the p	iment or diagnosis of HIV or AIDS (including test results) eral regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, R Parts 160 and 164. These rules prohibit the recipient from making any further disclosure of this he written consent of the person to whom it pertains or as otherwise permitted by law
PURPOSE FOR USE OR DISCLOSURE:Person	al UseTreatmentLegalOther
EXPIRATION: Unless another date, event or co date it is signed. Other date, event, or condition	ondition is listed below, this authorization will expire one (1) year from the in:
(1) research related, or (2) provided solely for the purpose to provide authorization under the aforementioned circu purposes. I understand that information disclosed by this authoriza disclosure by the recipient and may no longer be protect and the Privacy Act of 1974 (5 USC 552a) and Client has the providence of the purpose of the providence of the purpose of the purpose of the purpose of the purpose of the providence of the purpose of the	treatment or eligibility for care on my providing this authorization except if such care is e of creating Protected Health Information for disclosure to a third party. If Client refuses emstances, North Carolina Solutions may refuse to provide care or treatment for these action, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the reset by the Health insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) the right to revoke this authorization at any time in writing and upon delivery to North een taken in reliance on this authorization, or if applicable, during an insurance
	Date.
Client's Signature	
Signature ofParent/Legal Guardianif other,	Date:
Witness Signature	
-чицева окрижения	,



the undersigned hereby authorizes the release of	r information from the health record of:
ClientName:	Date of Birth:
from (person/agency) <i>NC SOLUTIONS</i>	TO (PERSON/AGENCY) Trillium Health Resources
FROM (PERSON/AGENCY) Trillium Health Resources	
INFORMATION AUTHORIZED FOR RELEASE (CHE	CK ALL THAT APPLY):
Admission/ Evaluation /CCAMedicationsDischarge SummaryLabsStaff NotesTreatment PropOther:	Medical/Physical History History/Psychosocial gressTesting
INFORMATION IDO I DO NOT authorize disclosure of record DO I DO NOT authorize disclosure of treatm Alcohol and/or drug treatment records are protected under feder and the Health Insurance Portability and Accessibility Act, 45 CFR Information unless further disclosure is expressly permitted by the	pent or diagnosis of HIV or AIDS (including test results) ral regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, Parts 160 and 164 These rules prohibit the recipient from making any further disclosure of this ewritten consent of the person to whom it pertains or as o the iwise permitted by law
	Use_Treatment_Legal_Other
EXPIRATION: Unless another date, event or condate it is signed. Other date, event, or condition	dition is listed below, this authorization will expire one (1) year from the
(1) research related, or (2) provided solely for the purpose to provide authorization under the aforementioned circum purposes. I understand that information disclosed by this authorization disclosure by the recipient and may no longer be protected and the Privacy Act of 1974 (5 USC 552a) and Client has the	eatment or eligibility for care on my providing this authorization except if such care is of creating Protected Health Information for disclosure to a third party, if Client refuses istances. North Carolina Solutions may refuse to provide care or treatment for these on, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the re-liby the Health Insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) a right to revoke this authorization at any time in writing and upon delivery to North in taken in reliance on this authorization, or if applicable, during an insurance
	Date:
Client's Signatura	
Signature ofParent/Legal Guardian If other, s	Date;
Witness Signature:	



I have read and received a copy of the NC Solutions policy regarding missed appointments and non-adherence to my treatment plan. I understand I can access my treatment plan upon request. I understand that missing scheduled appointments can interfere with my progress toward my treatment goals. As a result, I am aware that missed appointments may lead to the cancelation of future appointments. I am aware that questions regarding this policy can be discussed with my NC Solutions staff. I am aware that I may refuse treatment without consequence.

Signature	Date
Witness	Date

RIVERVALLEY CONSULTING SERVICES, INC. AND APPILIATED CORPORATIONS ("RiverValley")

INFORMED CONSENT FOR TELEHEALTH SERVICES

Patient's Name:		Date of b	oirth:
to ta dist	chealth means the use of a clicke place between a patient ant location. Telehealth muster of medical data, or me	t at one location and a me ay be utilized for diagnosi	
١.	I understand River Valley has	s requested me to engage in a t	telchealth service with _("medical specialist,")
2.	conferencing") technology v	as a direct patient/ provider vi	video conferencing ("video health service. I understand this isit due to the fact that I will not
3,	unauthorized access and tecl	health sorvice if it is felt that th	d that my RiverValley provider
4.	individuals for scheduling attaleheath service other than operate the video conference confidentiality of the information presence before the teleheat omit specific details of my personally sensitive to me; (nation obtained. I further under the service and will have the rig nedical/mental health history/ (2) ask non-medical personnel (b) terminate the telehealth servi	ay also be present during the medical specialist in order to intioned people will all maintain retand I will be informed of their ght to request the following: (1) physical examination that are
5,		to inspectall information obt nay receive copies of this info	ained and recorded in the course amation upon my request.
6,	apply to telehealth, and no i		ity of medical information also of telehealth which identifies me w.
7.	participate in a telehealth se	o a telehealth service explaine rvice, I understand that some p ucted by individuals at my loc tant location.	parts of the service involving
8.		estions regarding the process	sks and benefits of the telehealth explained. I hereby consent to
Pat	ient's/Parent's/Legal Repres	ontative's Signature	Date

RIVERVALLEY CONSULTING SERVICES NORTH CAROLINA SOLUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that RiverValley Consulting Services, Inc., and it affiliates including NORTH CAROLINA SOLUTIONS is part of an organized healthcare arrangement and that these providers may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information I used and shared. I understand the organized healthcare arrangement has the right to change this notice at any time. I further understand if I have any questions in the future, I have the right to have them answered by contacting NORTH CAROLINA SOLUTIONS or by visiting the site at www.rvbh.com.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

PRINT CLIENT FULL NAME	CLIENT SS#/ or MR#
CLIENT SIGNATURE	DATE
CLIENT LEGAL REPRESENTATIVE (if applicable)	DATE
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO CLIENT
WITNESS NAME (PRINT)/LOCATION COST CENTE	ir.

FOR PROVIDER USE ONLY:

RiverValley Consulting Services and its affiliates including NORTH CAROLINA SOLUTIONS have made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the HIPAA Notice of Privacy Practices:

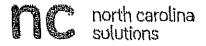
(Identify the efforts that were made to obtain the individual's written acknowledgment, including the reasons (if known) why acknowledgement was not obtained.)



North Carolina Solutions Authorization for Treatment and Notice of Financial Responsibility

Client Name______Date of Birth_____

Permission for Trea	tment:		
I hereby authorize t	he staff of Nortl	n Carolina Soluti	ons to render treatment and/or services to
			_whose relationship to me is (check one).
Self	Child	Spouse	Other (specify)
			hts and Responsibilities as a Patient/Client of River Valley Behavioral Health ven a Written explanation of these rights and responsibilities,
			have been given the opportunity to select the provider(s) of my choice (amould I become dissatisfied with my services
while engaged in se	ervices at North	Carolina Solutio	event that I or the Individual in my custody need emergency medical care ns I give permission for NC Solutions Staff to: 1) Administer emergency I them of the emergency; 3) contact my or the individual in my custody's
			h Carolina Solutions may contact you during the course of treatment and or your satisfaction with the service received at this agency,
and for any payable limited to Medicar	e benefit to be p e, Medicaid, con	oaid directly to N nmercial insurar	a Solutions to bill my third party payment source for biliable services received forth Caronia Solutions. Third party payment sources include but are not nce, and self-insured insurance plans. My signature or photocopy of my lie service are being received unless specifically revoked by me in writing
third party paymer payments sources	nt sources which to verify payabl ire shall be valid	are being billed benefits, to professing of	Party Payer Sources: I authorize River Valley Behavioral Health to furnish all ifor service provided to me with information necessary for that third party ocess claims and to process any payable benefits. My signature or a photo claims and payable benefited for an indefinite pariod while services are being
Medicare I will be Medicare recipient service not covere insurance or a self but not limited to between NC Soluti	responsible for a t. If I am covered by Medicare, I insurance insur deductible and d ions and mythin	any deductible, o d by Medicald, i Medicald detern ance plan, i will to insurances i d party paymeni	onsible for the charges for the services which I receive. If I am covered by co-insurance, or services not covered by Medicare and billable to the will be responsible for any continuing income amount, spend down or nines what these amounts are if I am covered by Champus, commercial be responsible for any amount not covered by my payment source such as am not responsible for any amount that represents a contractual agreement to source. Reduced fees are available based on a family size and income.
shall be considered	d as accomplish	edupon present	iue and payable in full upon recipient of services. Ademand for payment ation of a billing or a verbal or written request for payment. Failure to make necessary collection action as provided in State and Federal collection laws
Client Signature		Date	Responsible Party Signature Date
Witnessed		Date Date	



Permission to Video Record for Training Purposes

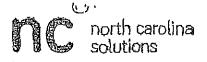
Dear Parents/Guardians:

We are committed to providing quality training, to our staff to insure the highest quality treatment for your child. Our new training program will be using video recording techniques. The recordings will only be viewed by NC Solutions staff for the purpose of training. All recordings will be kept confidential, The recording will help:

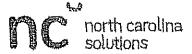
- · Provide feedback to staff to improve their performance
- Formally assess staff implementation of treatment plans
- Evaluate accuracy of data recording
- Evaluate and improve our training and assessment processes

This is a request for permission to allow your child to be recorded in the clinic setting for training purposes. Please check and fill out the information below that applies and return,

Ų	t'
	recording of my child (print child's first and last name) for the
	purpose of staff training and evaluation. I understand that video recordings will be used for training
	and evaluation purposes only,
	o Any other use of the recordings will require specific written permissionInitials
a	I, (print your first and last name) do not give
	permission for (print your child's first and last name) to be video recorded for staff training purposes.
	G.F. of Francisco
	•
	Signature of Parent/Guardian Date
FXPIR	ATION: Unless another date, event or condition is listed below, this authorization will expire one
	ar from the date it is signed, Other date, event, or condition:
(-) ,	The state of the s
	tand North Carolina Solutions may not condition treatment or eligibility for care on my providing this authorization
	f such care is (1) research related, or (2) provided solely for the purpose of creating Protected Health Information for
	re to a third party. If Chent refuses to provide authorization under the aforementioned circumstances. North Carolina is may refuse to provide care or treatment for these purposes.
	is triagration to provide to be treatment for these proposes.
	ire by the re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and
	ability Act Privacy Rule (45CFR Part 164) and the Privacy Act of 1974 (5 USC 552a) and Client has the right to revoke this
	ration at any time in writing and upon delivery to North Carolino Solutions except to the extent that action has been
taken in form	reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this
£ 17(1)}	



Auth	norization to	pick up a child	from NC	Solutions
Nan	ne of Child:_		·	
I here the al	by inform NC Solu bove named child.	tions that the people	<i>llsted below</i> tions is herel	are authorized to pick up by instructed to release
	f	NUTHORIZED PICK-UP	PERSON:	
	<u>Name</u>	<u>Relations f</u>	ip to Child	<u>Phone Number</u>
2.				
Lunde	erstand that:			
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	Parent/Guardian	Signature	 -	 Date
	Witnessed by NC	Solutions Staff		



February 10, 2020

To our parents and caretakers:

We are now providing an assortment of edible reinforcers to assist in the reinforcement and motivation of our clients as part of their therapy. These are small pieces of food—for example, Skittles, popcorn, marshmallows, etc. and are given in small amounts throughout their session/s. Please note that this list is only an example.

We are aware of our clients' specific dietary restrictions, so we will only use edibles that do not violate these restrictions.

If your child's dietary restrictions have changed, or if you have any questions or concerns about the use of edible reinforcers, please contact, Clinic Coordinator, Kristin Nelson.

If you would like to bring in your own, you are welcome. Additionally, if there are specialized edibles that you think we may not have but want us to buy, you are also welcome to let us know.

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February 19, 2019

Dear parents/guardians;

On occasion, different snack or food items are brought into our office for staff or clients. For example, if someone is celebrating a birthday, they may bring in cupcakes to celebrate with their friends.

If your child expresses interest in these items, we would like permission to give them some of those items (in moderation). We are aware of client's specific allergies and would take that into close consideration.

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Thank you for your attention to this matter @