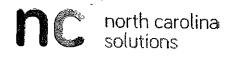


BIOGRAPHICAL INFORMATION (Child) - INTAKE FORM NAME: ______ DATE: _____ DATE OF BIRTH/PLACE: _____ AGE:____ SCHOOL AND GRADE: PERSON AND PHONE#. TO CALL IN EMERGENCY: REFERRAL SOURCE: EMAIL ADDRESS: PRESENTING PROBLEM (be as specific as you can; when did it start, how does it affect you and the child's life...): PARENTS/STEP-PARENT (name/age or year of death/cause of death, occupation, personality, how did s/he treat the client, brief statement about the relationship): Father: Step - parents: Other/Legal Guardian (and relationship to client):

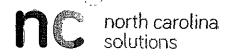


TEDICAL DOCTOR/S (name/phone);	
AST/PRESENT MEDICAL CARE (majormedical problems, surgeries, accidents, fal	ls, illness).
pecify all MEDICATIONS the child is presently taking and for what:	
AGGRESIVE or VIOLENT BEHAVIOR (describe: age/s, reasons, circumstances, hov	v, etc):
ADDITIONAL PROBLEMATIC BEHAVIORS (self-mjunous behavior, elopement, plestruction, disrobing, self-stimulatory behavior, etc.):	торетту



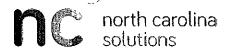
FAMILY MEDICAL HISTORY (Describe any illness/disability that runs in the family: Intellectual Disability, ADHD, Autism, epilepsy, etc.).		
FRIE)	NDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):	
LIKE	S AND DISLIKES/STRENGTHS AND WEAKNESSES.	
sessio	PRESENT THERAPIES/ABA (specify: month, year/s (beginning-end), estimated no. of ons, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, description of the relationship and how helpful it was, and how/why it ended):	
1		
2		
-		
3		

4. USE OTHER SIDE OF PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS



DESCRIBE YOUR CHILD'S SOCIAL INTERACTIONS (Relationships with parents, siblings, other school, neighborhood, relocations, any school/behavioral/problems):		
IF PARENTS DIVORCED: Your child's age at the time: Describe how it affected them:		
FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (Including suicide, depression, hospitalizations in mental institutions, abuse, etc.):		
What gives your child the most joy or pleasure in their life?		
What are your main worries and fears?		
What are your most important hopes or dreams?		

Please add on the other side of this page or on a separate page any other information you would like me to know about you and your situation



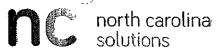
(Print Name & Relationship to Minor)

3904 Oleander Dr #102 Wilmington, NC 28403 PH: 910-313-3232 FAX: 910-313-6598

CONSENT FOR TREATMENT FOR MINOR(S) give my consent to (Parent(s) /Guardian(s)) who will be conducting psychotherapy, (Psychologist/Therapist) psychological/ neuropsychological testing with _______(Minor's Name) My relationship to the minor is: I was notified that the holder of the privilege is I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality as outlined in the Office Policies and General Information, which I have read and signed. In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept the psychologist/ therapist's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well-being. (Print Name & Relationship to Mmor) (Signature)

(Signature)

(Date)



3904 Oleander Dr #102 Wilmington, NC 28403-PH: 910-313-3232 FAX: 910-313-6598

Authorization for Use and Disclosure

Patient Name							
	Last		First	MI		iden or Other l	Vame
Date of Birth:					one'	Zip:	
Address:		City		or All Da	ites of Servic		
•				nd disclose my c			mation for it's
				care operations.	mas proses	,,,	
🗆 I zuthe	rize Dr. K	Cerri Wright,	Psy.D to di	sclose the follo	wing records	s related to th	e date above:
Reco	rds: [[AII]	Records	□м	ental Health Note	\$		
			□Ps	ychological/Neur	opsychologic	cal Testing	
			∐BiI	ling, Insurance, a	nd Account I	information	
				er:			
			□v	erbal Discussion (Only		
COVERED I	TTTY	or INDIVIDUA	AL Name:_				
Address.			City:		ST:_	Zip.	
Phone:			_Fax'				
Tayadond the	t mu shilde	renards might i	nclude notes	that reflect sessio	me in which i	I participated I	understand that
any such doen	nentation is	s a part of m	<i>v</i> child's re	cords, and I au	thorize the i	release of anv	such records
•		•	•	•		•	
I understand the	ıt my medic	al doctor psycl	hologist/thera	pist generally m	ay not condi	tion medical o	r psychological
•				edical or psycho			
purpose	of c	eating l	nealth	Information	for	a thir	d party.
				ents, and I do h horization is mad			
I understand the Drug	it my record	ls are protected	under the fe	deral regulations	governing (Confidentiality	of Alcohol and Abuse
Pottent Peraris	ፈን ሮዋወ ው	rt 2 and the He	alth Incuranc	e Portability and	Accountabili	ity Act of 1996	("HIPAA") 45
CFR Parts 160 d	k 164 and st	ite confidentiali	ty law govern	ung substance abi	use services (G,S 122C) can	not be disclosed
without my			unless c	therwise pro	vided for		regulations
I also understa taken in relianc	nd that I m e on it {refe	ay revoke this r to Privacy No	consent in vitice}, and the	vriting at any tiv at in any event th	me except to as consent ex	the extent that pires automatic	action has been cally as follows
This authorizati	on expires o	ne year from th	e date of sign	ing on:			
			_ or	GAL GUARDIAN/A			
SIGNATURE OF	PATIENT .	DATE	PARENT/LE	GAL GUARDIAN/A	UTHORIZED.	Person	DATE
RELATIONSHIP	TO PATIENT	.					



HIPAA Notification

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to protect the confidentiality of your Protected Health Information. We also are required to provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. In addition we are required to abide by the terms of the privacy notice currently in effect. Protected Health Information (PHI) is individually identifiable health information related to your health conditions, health care provided to you, or payments made for that care, which is created or received by a health plan, a health care clearinghouse, or a health care provider that electronically transmits such information.

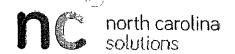
How We Use and Disclose Protected Health Information

The agency may use and disclose your Protected Health Information as permitted by law. This notice describes how we are most likely to use and disclose Protected Health Information. We will use and disclose Protected Health Information for treatment, payment, and health care operations. The following are examples of these permitted uses and disclosures of PHI:

- Payment' includes activities undertaken by the agency to obtain premiums or to determine or fulfill its responsibility for coverage and provision of plan benefits, such as determination of eligibility, coverage and cost sharing amounts;
- 'Health care operations' include rating provider and plan performance, quality assessment and improvement, business management and general administrative activities; and
- "Treatment' includes provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

We also may use or disclose PHI in the following circumstances:

- When we are required to do so by law, such as if a government agency is determining our compliance with the law;
- For public health activities, such as preventing or controlling the spread of communicable diseases;
- In order to report suspected abuse, neglect, or domestic violence;
- In cooperation with agencies that carry out health oversight activities, such as audits, investigations, inspections, licensure, and other criminal or civil proceedings;
- In connection with legal proceedings, such as in response to a court order, administrative order, or subpoena;



- In cooperation with law enforcement, such as in connection with a subpoena or court
 order; the locations of suspects, fugitives, witnesses and missing persons; investigations
 of crimes on the premises; and where the PHI relates to the victim of a crime;
- When reasonably necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
- In connection with activities related to worker's compensation, such as the provision of benefits for work-related injuries or illnesses and compliance with worker's compensation laws; and
- For the purpose of modifying, amending, or terminating the Plan; obtaining premium bids from health plans for providing health insurance coverage; and to perform plan administrative functions (such as claims processing, quality assurance, auditing and monitoring).

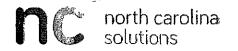
Other uses and disclosures will be made only with your written authorization, which you may choose to give us in order to use or disclose your PHI for purposes not described in this notice. If you have provided an authorization, you may revoke it at any time by giving us written notice of your revocation. Your revocation will not affect uses and disclosures undertaken while your authorization was in effect.

You have rights with respect to your PHI. You have the right to:

- Request restrictions on certain uses and disclosures of PHI as provided by HIPAA, but the agency may not be required to agree to a requested restriction.
- Receive confidential communications of PHI at reasonable alternative locations and by reasonable alternative means if you believe that our disclosure of PHI could endanger you;
- · Access, inspect and copy certain PHI, for which we may require a reasonable fee;
- Request that we amend or update PHI, but the agency may not be required to agree to the request, in which case we will inform you of our decision in writing and you will have the right to submit a written statement of disagreement;
- Receive an accounting of certain types of disclosures of PHI made by the agency in the six years prior to the date on which the accounting is requested, as provided by HIPAA (we may charge you a reasonable fee for this accounting if you have made a request more than once in a twelve month period); and
- Obtain a paper copy of this notice from the agency upon request.

If you behave your rights under HIPAA have been violated, you have the right to file a complaint with the agency by contacting Mentoring Minds for Mental Health at 910.792.5570. You also may file a complaint with the U.S. Department of Health and Human Services.

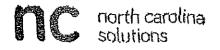
The agency reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains. If the notice is revised in a manner that materially changes its terms, the agency will offer individuals with a copy of the



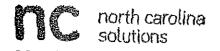
revised notice within 60 days of the revision. All revised notices will be distributed in the same manner as this notice or as otherwise permitted or required by HIPAA. You may also request a copy of the current privacy notice at any time by contacting our office at 910.792-5570.

By signing below, you are inducating that you have read all the above notices.

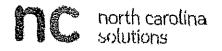
Client Name	Date of Birth
Parent or Legal Guardian, Print Name	Date
Signature of Client or Legal Guardian Relationship to Client	Date



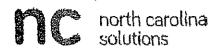
The unders	lgned hereby authorizes the release o	of information from the health record of:
Client Nam	le:	Date of Birth:
	from (Person/agency) _ <i>NC SOLUTIONS</i>	TO (PERSON/AGENCY)DR. Kerrl Wright, PSY
		TO (PERSON/AGENCY) NC SOLUTIONS
	Dr. Kerri Wright TION AUTHORIZED FOR RELEASE (CH	ECH AN THAT ADDIVI
Admissi	Included the original control of the	Medical/Physical History History/Psychosocial
YOU MUST INFORMAT INFORMAT INFORMAT INFORMAT INFORMAT Alcohol and, and the Heal Information	ION: I DO NOT authorize disclosure of recordI DO NOT authorize disclosure of treath /or drug treatment records are protected under fede /th insurance Portability and Accessibility Act, 45 CFI unless further disclosure is expressly permitted by the	nent or diagnosis of HIV or AIDS (including test results) rairegulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part2, 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 periains or as otherwise permitted by law
PURPOSE	FOR USE OR DISCLOSURE:Person	al UseTreatmentLegalOther
	ON: Unless another date, event or co- signed. Other date, event, or condition	ndition is listed below, this authorization will expire one (1) year from the
I understand North Carolina Solutions may not condition treatment or eligibility for care on my providing this authorization except if such care is (1) research related, or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. If Client refuses to provide authorization under the aforementioned circumstances. North Carolina Solutions may refuse to provide care or treatment for these purposes. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the redisclosure by the recipient and may no longer be protected by the Health insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) and the Privacy Act of 1974 (5 USC552a) and Client has the right to revoke this authorization at any time in writing and upon delivery to North Carolina Solutions except to the extent that action has been taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.		
P1723. p1		Date:
Cllent's Si	-	
Signature	ofParent/Legal Guardianif other, s	Date Date Date Date Date Date Date Date
Witness S	Signature:	Date:



ClientName:	Date of Birth:
from (person/agency) <i>NC SOLUTIONS</i>	TO (PERSON/AGENCY)
FROM (PERSON/AGENCY) Primary Care Dr:	TO (PERSON/AGENCY)NC SOLUTIONS
INFORMATION AUTHORIZED FOR RELEASE	(CHECK ALLTHAT APPLY):
Admission/ Evaluation / CCAMedicationDischarge SummaryLabsStaff NotesTreatmenOther,	onsMedical/Physical History History/Psychosocial Testing
INFORMATION:	records of alcohol or drug abuse treatment. treatment or diagnosis of HIV or AIDS (including test results) er federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 45 CFR Parts 160 and 164. These rules prohibit the recipient from making any further disclosure of this adopt the written consent of the person to whomit pertains or as o therwise permitted by law rsonal UseTreatmentLegalOther
EXPIRATION: Unless another date, event of date it is signed. Other date, event, or cond	or condition is listed below, this authorization will expire one (1) year from the dition:
(1)research related, or (2) provided solely for the put to provide authorization under the aforementioned purposes, i understand that information disclosed by this authorisation by the recipient and may no longer be provided that Privacy Act of 1974 (5 USC 552a) and Client	ortion treatment or eligibility for care on my providing this authorization except if such care is impose of creating Protected Health Information for disclosure to a third party. If Client refuses circumstances. North Carolina Solutions may refuse to provide care or treatment for these increation, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the re-otected by the Health Insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) has the right to revoke this authorization at any time in writing and upon delivery to North has been taken in reliance on this authorization, or if applicable, during an insurance orth.
	Date:
Client's Signature	
Signature ofParent/Legal Guardian if ot	Date,
Witness Signature:	Date:



he undersigned hereby authorizes the release	e of information from the health record of: Date of Birth;
	TO (PERSON/AGENCY)
	School:
	TO (PERSON/AGENCY) <i>NC SOLUTIONS</i>
INFORMATION AUTHORIZED FOR RELEASE (C	HECK ALL THAT APPLY):
Admission/ Evaluation /CCAMedicationsLabsLabsTreatment POther:Treatment P	History/Psychosocial rogress Testing
INFORMATION: IDOI DO NOT authorize disclosure of recomposition of the process of th	HE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH ords of alcohol or drug abuse treatment. Settment or diagnosis of HIV or AIDS (including test results) Seteral regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Parts 2 CFR Parts 160 and 164. These rules prohibit the requent from making any further disclosure of this by the written consent of the person to whom it pertains or as otherwise permitted by law, on all Use Treatment Legal Other
EXPIRATION: Unless another date, event or date it is signed. Other date, event, or condition	condition 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 circ purposes. I understand that information disclosed by this authorized disclosure by the recipient and may no longer be protected and the Privacy Act of 1974 (5 USC 552a) and Client has	In treatment or eligibility for care on my providing this authorization except if such care is see of creating Protected Health information for disclosure to a third party. If Client refuses cumstances North Carolina Solutions may refuse to provide care or treatment for these sation, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the rested 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 been taken in reliance on this authorization, or if applicable, during an insurance
mtrla fil an udanua	Date ·
Client's Signature	D
Signature ofParent/Legal Guardianif other	, specify relationship:
Witness Signature:	Date:



•	ase of information from the health record of: Date of Birth:
Cheff (varde)	pate of this in
FROM (PERSON/AGENCY)	TO (PERSON/AGENCY)
NC SOLUTIONS	Trillium Health Resources
FROM (PERSON/AGENCY) Trillium Health Resources	TO (PERSON/AGENCY) <i>NC SOLUTIONS</i>
INFORMATION AUTHORIZED FOR RELEASE	(CHECK ALL THAT APPLY):
Admission/ Evaluation /CCAMedicationDischarge SummaryLabsStaff NotesTreatmenOther:	onsMedical/Physical History History/Psychosocial at ProgressTesting
INFORMATION IDO I DO NOT authorize disclosure of r IDO I DO NOT authorize disclosure of the second and/or drug treatment records are protected under and the Health Insurance Portability and Accessibility Act,	THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH records of alcohol or drug abuse treatment. Treatment or diagnosis of HIV or AIDS (including test results) Free federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, 45 CFR Parts 160 and 164 These rules prohibit the recipient from making any further disclosure of this end by the written consent of the person to whom it pertains or as a therwise permitted by law
PURPOSE FOR USE OR DISCLOSURE:Per	rsonal UseTreatmentLegalOther
EXPIRATION: Unless another date, event of date it is signed. Other date, event, or cond	or condition is listed below, this authorization will expire one (1) year from the dition:
(1) research related, or (2) provided solely for the put	tion treatment or eligibility for care on my providing this authorization except if such care is those of creating Protected Health Information for disclosure to a third party. If Client refuses circumstances, North Carolina Solutions may refuse to provide care or treatment for these
disclosure by the recipient and may no longer be pro and the Privacy Act of 1974 (5 USC 552a) and Client	orization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the re- otected by the Health Insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) has the right to revoke this authorization at any time in writing and upon delivery to North has been taken in reliance on this authorization, or if applicable, during an insurance rm.
	Date:
Client's Signature	
Signature of Parent/Lead Guardian If or	her, specify relationship:
	Date:

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

INFORMED CONSENT FOR TELEHEALTH SERVICES

Patient's Name:		Date of birth:		
to to dist	ake place between a pa	of a two way interactive video to dient at one location and a medic in may be utilized for diagnosis, or medical education.	al specialist at another	
1.	I understand RiverValle	ey has requested me to engage in a tele	chealth service with medical specialist.")	
2.	conferencing'') technol	ned to me how two-way interactive viogy will be used to provide the teleher same as a direct patient/provider visit the medical specialist.	alth service. I understand this	
3,	unauthorized access an	potential risks to this technology, included technical difficulties. I understand to telehealth service if it is felt that the equate for the situation.	hat my RiverValley provider	
4.	individuals for schedul teleheath service other operate the video confidentiality of the inpresence before the teleomit specific details of personally sensitive to	cal and/or mental health information many and billing purposes. Others may than my River Valley provider and meterencing equipment. The above mention obtained. I further understehealth service and will have the right my medical/mental health history/phyme; (2) ask non-medical personnel to d/or (3) terminate the telelealth service or treatment.	also be present during the edical specialist in order to oned people will all maintain and I will be informed of their to request the following: (1) ysical examination that are leave the telehealth	
5,		right to inspect all information obtain and may receive copies of this inform		
б.	apply to telehealth, and	hat protect privacy and confidentiality d no information obtained in the use of out my consent unless required by law.	telehealth which identifies me	
7.	participate in a telehea	ives to a telehealth service explained to Ith service, I understand that some par conducted by individuals at my locate te distant location.	ts of the service involving	
8.	service and have had n	nent carefully, and understand the risks my questions regarding the process exp ealth service(s) requested.		
Pa	tient's/Parent's/Legal Re	epresentative'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	JR

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FOR PROVIDER USE ONLY:

River Valley 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 acknowledgment was not obtained.)

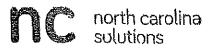


North Carolina Solutions Authorization for Treatment and Notice of Financial Responsibility

_____Date of Birth___

Client Name__

Permission for Treatme I hereby authorize the s		to render treatment and/or services to
	w	hose relationship to me is (check one).
Self	_ChildSpouse	Other (specify)
		and Responsibilities as a Patient/Client of River Valley Behavioral Health a written explanation of these rights and responsibilities.
		been given the opportunity to select the provider(s) of my choice if am I become dissatisfied with my services
while engaged in servi	ces at North Carolina Solutions I	nt that I or the Individual in my custody need emergency medical care give permission for NC Solutions Staff to: 1) Administer emergency em of the emergency; 3) contact my or the individual in my custody's
		arolina Solutions may contact you during the course of treatment and or satisfaction with the service received at this agency.
and for any payable be limited to Medicare, N	enefit to be paid directly to Nort Medicaid, commercial insurance,	olutions to bill my third party payment source for billable services received In Caronia Solutions. Third party payment sources include but are not and self-insured insurance plans. My signature or photocopy of my service are being received unless specifically revoked by me in writing
third party payments payments sources to	ources which are being billed for verify payable benefits, to proce shall be valid for processing clair	rty Payer Sources: I authorize River Valley Behavioral Health to furnish all service provided to me with information necessary for that third party is claims and to process any payable benefits. My signature or a photoms and payable benefited for an indefinite period while services are being
Medicare I will be responded care recipient. It service not covered by insurance or a self-insurance or a	ponsible for any deductible, co- flam covered by Medicald, I will y Medicare, Medicaid determine surance insurance plan, I will be fuctible and co insurances I am s and mythird party payment so	ble for the charges for the services which I receive. If I am covered by hisurance, or services not covered by Medicare and billable to the I be responsible for any continuing income amount, spend down or as what these amounts are if I am covered by Champus, commercial responsible for any amount not covered by my payment source such as not responsible for any amount that represents a contractual agreement urce. Reduced fees are available based on a family size and income. I hink you may be qualify for reduced fees.
shall be considered as	s accomplished upon presentation	and payable in full upon recipient of services. A demand for payment on of a billing or a verbal or written request for payment. Failure to make essary collection action as provided in State and Federal collection laws
Client Signature	Date	Responsible Party Signature Date
Witnessed	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.

L	1,	_(print your first and last name) hereby authorize video
	recording of my child	(print child's first and last name) for the
	purpose of staff training and evaluation.	I understand that yideo recordings will be used for training
	and evaluation purposes only.	
	o Any other use of the recordings	will require specific written permissionInitials
	· ·	* A A
:	T	Z1
	ــــــــــــــــــــــــــــــــــــــ	(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 p	ourposes.
		_
		•
	,	
		Signature of Parent/Guardian Date
EXPIRATION: Unless another date, event or condition is listed below, this authorization will expire one		
(1) year from the date it is signed. Other date, event, or condition:		
I understand North Carolina Solutions may not condition treatment or eligibility for care on my providing this authorization		
except if such care is (1) research related, or (2) provided solely for the purpose of creating Protected Health Information for		
disclosure to a third party. If Client refuses to provide authorization under the aforementioned circumstances. North Carolina		
Solutions may refuse to provide care or treatment for these purposes		
I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to re-		
disclosure by the re-disclosure by the recipient and may no longer be protected by the Health insurance Portability and Accountability Act Privacy Rule (45CFR Part 164) and the Privacy Act of 1974 (5 USC 552a) and Client has the right to revoke this		
authorization at any time in writing and upon delivery to North Carolina Solutions except to the extent that action has been		
		ring an insurance contestability period. I may request a copy of this
form	• • • •	,, , , , , , , , , , , , , , , , , , , ,