north carolina solutions

BIOGRAPHICAL INFORMATION (Child) - INTAKE FORM

NAME: _____ **M/F:**_____ **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: _____

_____

Mother: _____

_____

Step - parents:

_____

_____

Other/Legal Guardian (and relationship to client):

_____

_____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship).

MEDICAL DOCTOR/S (name/phone):

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness).

Specify all MEDICATIONS the child is presently taking and for what:

AGGRESIVE or VIOLENT BEHAVIOR (describe: age/s, reasons, circumstances, how, etc):

ADDITIONAL PROBLEMATIC BEHAVIORS (self-injurious behavior, elopement, property destruction, disrobing, self-stimulatory behavior, etc.):

FAMILY MEDICAL HISTORY (Describe any illness/disability that runs in the family: Intellectual Disability, ADHD, Autism, epilepsy, etc).

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

_____

_____

_____

LIKES AND DISLIKES/STRENGTHS AND WEAKNESSES.

_____

_____

_____

PAST/PRESENT THERAPIES/ABA (specify: month, year/s (beginning-end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief 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, others, 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

north carolina solutions

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

CONSENT FOR TREATMENT FOR MINOR(S)

I, _____,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 Minor) (Signature) (Date)

_____

(Print Name & Relationship to Minor) (Signature) (Date)

north carolina solutions

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 Maiden or Other Name
Date of Birth: ___-___-_____ Medical Record #._____ Phone:_____
Address:_____ City._____ ST._____ Zip:_____
Date of Service:_____ or ☐ All Dates of Service

☐ **I authorize Dr. Kerri Wright, Psy.D** to use and disclose my child's protected health information for it's own purposes of treatment, payment, and health care operations.

☐ **I authorize Dr. Kerri Wright, Psy.D** to disclose the following records related to the date above:

Records: ☐ All Records
☐ Mental Health Notes
☐ Psychological/Neuropsychological Testing
☐ Billing, Insurance, and Account Information
☐ Other:_____
☐ Verbal Discussion Only

☐ COVERED ENTITY ☐ or INDIVIDUAL Name:_____

Address._____ City:_____ ST:_____ Zip._____

Phone:_____ Fax:_____

I understand that my child's records might include notes that reflect sessions in which I participated I understand that any such documentation is a part of my child's records, and I authorize the release of any such records.

I understand that my medical doctor psychologist/therapist generally may not condition medical or psychological services upon my signing an authorization unless the medical or psychological services are provided to me for the purpose of creating health Information for a third party.

I have carefully read and understand the above statements, and I do herein expressly and voluntarily consent to disclosure of the above Information I certify that this authorization is made freely, voluntarily, and without coercion.

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 the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it {refer to Privacy Notice}, and that in any event this consent expires automatically as follows.

This authorization expires one year from the date of signing on: _____

_____ _____ or _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED 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 believe 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 indicating 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

nc north carolina solutions

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

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	DR. Kerri Wright, PSY
__FROM (PERSON/AGENCY)	__TO (PERSON/AGENCY)
Dr. Kerri Wright	NC SOLUTIONS

INFORMATION AUTHORIZED FOR RELEASE (CHECK ALL THAT APPLY):

___Admission/ Evaluation /CCA ___Medications ___Medical/Physical History
___Discharge Summary ___Labs ___History/Psychosocial
___Staff Notes ___Treatment Progress ___Testing
___Other: _____

RELEASE OF SPECIAL RECORDS

YOU MUST CHECK ( ) A RESPONSE TO EACH OF THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH INFORMATION:

___I DO ___I DO NOT authorize disclosure of records of alcohol or drug abuse treatment.
___I DO ___I DO NOT authorize disclosure of treatment or diagnosis of HIV or AIDS (including test results)

Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164. These rules prohibit the recipient 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 law.

PURPOSE FOR USE OR DISCLOSURE: __Personal Use __Treatment __Legal __Other _____

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 taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

_____ Date: _____
Client's Signature

_____ Date: _____
Signature of __*Parent/Legal Guardian* __If other, specify relationship: _____

Witness Signature: _____ Date: _____

nc north carolina solutions

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

Client Name: _____ Date of Birth: _____

__FROM (PERSON/AGENCY)
NC SOLUTIONS
_____

__TO (PERSON/AGENCY)
Primary Care Dr: _____
_____

__FROM (PERSON/AGENCY)
Primary Care Dr: _____
_____

__TO (PERSON/AGENCY)
NC SOLUTIONS
_____

INFORMATION AUTHORIZED FOR RELEASE (CHECK ALL THAT APPLY):

___Admission/ Evaluation /CCA ___Medications ___Medical/Physical History
___Discharge Summary ___Labs ___History/Psychosocial
___Staff Notes ___Treatment Progress ___Testing
___Other. _____

RELEASE OF SPECIAL RECORDS

YOU MUST CHECK ( ) A RESPONSE TO EACH OF THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH INFORMATION:

___I DO ___I DO NOT authorize disclosure of records of alcohol or drug abuse treatment.
___I DO ___I DO NOT authorize disclosure of treatment or diagnosis of HIV or AIDS (including test results)

Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164. These rules prohibit the recipient 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 law

PURPOSE FOR USE OR DISCLOSURE: __Personal Use __Treatment __Legal __Other _____

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 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.

_____ Date: _____
Client's Signature

_____ Date. _____
Signature of __Parent/Legal Guardian __if other, specify relationship: _____

Witness Signature: _____ Date: _____

nc north carolina solutions

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

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	School: _____
_____	_____
__FROM (PERSON/AGENCY)	__TO (PERSON/AGENCY)
School: _____	NC SOLUTIONS
_____	_____

INFORMATION AUTHORIZED FOR RELEASE (CHECK ALL THAT APPLY):

___Admission/ Evaluation /CCA	___Medications	___Medical/Physical History
___Discharge Summary	___Labs	___History/Psychosocial
___Staff Notes	___Treatment Progress	___Testing

___Other: _____

RELEASE OF SPECIAL RECORDS

YOU MUST CHECK ( ) A RESPONSE TO EACH OF THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH INFORMATION:

___I DO ___I DO NOT authorize disclosure of records of alcohol or drug abuse treatment.

___I DO ___I DO NOT authorize disclosure of treatment or diagnosis of HIV or AIDS (including test results)

Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the *Health Insurance Portability and Accessibility Act*, 45 CFR Parts 160 and 164. These rules prohibit the recipient 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 law.

PURPOSE FOR USE OR DISCLOSURE: __Personal Use __Treatment __Legal __Other _____

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 taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

_____ Date: _____

Client's Signature

_____ Date: _____

Signature of __*Parent/Legal Guardian* __if other, specify relationship: _____

Witness Signature: _____ Date: _____

nc north carolina solutions

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

Client Name: _____ **Date of Birth:** _____

__FROM (PERSON/AGENCY)
NC SOLUTIONS

__TO (PERSON/AGENCY)
Trillium Health Resources

__FROM (PERSON/AGENCY)
Trillium Health Resources

__TO (PERSON/AGENCY)
NC SOLUTIONS

INFORMATION AUTHORIZED FOR RELEASE (CHECK ALL THAT APPLY):

___Admission/ Evaluation /CCA ___Medications ___Medical/Physical History
___Discharge Summary ___Labs ___History/Psychosocial
___Staff Notes ___Treatment Progress ___Testing
___Other: _____

RELEASE OF SPECIAL RECORDS

YOU MUST CHECK ( ) A RESPONSE TO EACH OF THE FOLLOWING STATEMENTS IN THE EVENT YOUR RECORD MAY CONTAIN SUCH INFORMATION:

___I DO ___I DO NOT authorize disclosure of records of alcohol or drug abuse treatment.
___I DO ___I DO NOT authorize disclosure of treatment or diagnosis of HIV or AIDS (including test results)

Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164. These rules prohibit the recipient 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 law.

PURPOSE FOR USE OR DISCLOSURE: __Personal Use __Treatment __Legal __Other _____

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 taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

_____ **Date:** _____
Client's Signature

_____ **Date:** _____
Signature of __*Parent/Legal Guardian* __If other, specify relationship: _____

Witness Signature: _____ **Date:** _____

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

INFORMED CONSENT FOR TELEHEALTH SERVICES

Patient's Name:_____ Date of birth:_____

Telehealth means the use of a two way interactive video to permit a real-time service to take place between a patient at one location and a medical specialist at another distant location. Telehealth may be utilized for diagnosis, consultation, treatment, transfer of medical data, or medical education.

1. I understand RiverValley has requested me to engage in a telehealth service with _____ ("medical specialist.")

2. RiverValley has explained to me how two-way interactive video conferencing ("video conferencing") technology will be used to provide the telehealth service. I understand this service will not be the same as a direct patient/ provider visit due to the fact that I will not be in the same room as the medical specialist.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my RiverValley provider or I can discontinue the telehealth service if it is felt that the video conferencing connections are not adequate for the situation.

4. I understand my medical and/or mental health information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the teleheath service other than my RiverValley provider and medical specialist in order to operate the video conferencing equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand I will be informed of their presence before the telehealth service and will have the right to request the following: (1) omit specific details of my medical/mental health history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth service at any time without affecting my right to future care or treatment.

5. I understand I have the right to inspect all information obtained and recorded in the course of a telehealth service, and may receive copies of this information upon my request.

6. I understand the laws that protect privacy and confidentiality of medical information also apply to telehealth, and no information obtained in the use of telehealth which identifies me will be disclosed without my consent unless required by law.

7. I have had the alternatives to a telehealth service explained to me, and in choosing to participate in a telehealth service, I understand that some parts of the service involving physicial tests may be conducted by individuals at my location at the direction of the medical specialist at the distant location.

8. I have read this document carefully, and understand the risks and benefits of the telehealth service and have had my questions regarding the process explained. I hereby consent to participate in the telehealth service(s) requested.

_____ _____
Patient's/Parent's/Legal Representative'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 CENTER _____

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.)

nc north carolina solutions

North Carolina Solutions Authorization for Treatment and Notice of Financial Responsibility

Client Name_____ Date of Birth_____

Permission for Treatment:

I hereby authorize the staff of North Carolina Solutions to render treatment and/or services to:

_____whose relationship to me is (check one).

_____Self _____Child _____Spouse _____Other (specify) _____

Patient Rights: I hereby acknowledge that my Rights and Responsibilities as a Patient/Client of River Valley Behavioral Health have been explained to me and that I have been given a written explanation of these rights and responsibilities.

Right to Choose a Provider: I acknowledge that I have been given the opportunity to select the provider(s) of my choice I am aware that I can change provider(s) at any time should I become dissatisfied with my services

Consent for Emergency Medical Services: In the event that I or the individual in my custody need emergency medical care while engaged in services at North Carolina Solutions I give permission for NC Solutions Staff to: 1) Administer emergency medical care, 2) Contact family members to inform them of the emergency; 3) contact my or the individual in my custody's physician

Notification of Follow Up: Representative of North Carolina Solutions may contact you during the course of treatment and or following discharge from treatment to determine your satisfaction with the service received at this agency.

Assignment of Benefits: I authorize North Carolina Solutions to bill my third party payment source for billable services received and for any payable benefit to be paid directly to North Caronia Solutions. Third party payment sources include but are not limited to Medicare, Medicaid, commercial insurance, and self-insured insurance plans. My signature or photocopy of my signature shall be valid for an indefinite period while service are being received unless specifically revoked by me in writing

Authorization for Release of Information to Third Party Payer Sources: I authorize River Valley Behavioral Health to furnish all third party payment sources which are being billed for service provided to me with information necessary for that third party payments sources to verify payable benefits, to process claims and to process any payable benefits. My signature or a photo copy of my signature shall be valid for processing claims and payable benefited for an indefinite period while services are being received unless specifically revoked by me

Payment Agreement: I understand that I am responsible for the charges for the services which I receive. If I am covered by Medicare I will be responsible for any deductible, co-insurance, or services not covered by Medicare and billable to the Medicare recipient. If I am covered by Medicaid, I will be responsible for any continuing income amount, spend down or service not covered by Medicare, Medicaid determines what these amounts are If I am covered by Champus, commercial insurance or a self-insurance insurance plan, I will be responsible for any amount not covered by my payment source such as but not limited to deductible and co insurances I am not responsible for any amount that represents a contractual agreement between NC Solutions and my third party payment source Reduced fees are available based on a family size and income. Please ask a Customer Service Representative if you think you may be qualify for reduced fees

All charges which I am legally responsible for are due and payable in full upon recipient of services. A demand for payment shall be considered as accomplished upon presentation of a billing or a verbal or written request for payment Failure to make payment may result in NC Solutions initiating any necessary collection action as provided in State and Federal collection laws

_____ _____

Client Signature Date Responsible Party Signature Date

_____

Witnessed Date

nc north carolina solutions

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.

☐ I, _____(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 video recordings will be used for training and evaluation purposes only.

- Any other use of the recordings will require specific written permission. _____Initials

☐ 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.

_____
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 taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form