3C LINICAL COUNSELING
&Consulting Services, PLLC
ASSESSMENT AND TREATMENT CENTER
2931 Breezewood Avenue Suite 200 Fayetteville, NC 28303
Phone:910-748-0833 Fax:910-827-6592

Referral for Services

Section I: Referral Source Demographics

Referral Source: _____ **Date**: _____

Referral Source Phone Number: _____

Referral Source Email Address: _____

Section II: Service Request

Check all Desired Services: ☐Emotional and Behavioral Psychotherapy ☐Trauma-Focused-CBT

☐Psychosexual Evaluation ☐Trauma Assessment ☐CCA/Mental Health Evaluation ☐Psychosexual/Sex Offender Treatment ☐ Eating Disorder Treatment ☐ Psychological Evaluation ☐ ABA Therapy

☐ Medication Management ☐ Addictions Evaluation ☐ Addictions Treatment ☐ Autism Evaluation

☐ Disability Benefits Questionnaire (DBQ)-Veterans only ☐ Parenting Evaluation ☐ Family Assessment

Section III: Patient Demographics

Patient Name: _____

DOB: _____ **Age**: _____ **Gender:** _____

Race/Ethnicity: _____

SSN#: _____ **Primary Language:** _____

Insurance Carrier: _____ **Insurance Policy Number:** _____

Address: _____ **Phone Number:** _____

Section V: Reason for Referral

_____

_____

_____

_____

_____

CLINICAL COUNSELING
&Consulting Services, PLLC
ASSESSMENT AND TREATMENT CENTER

Adult Admission Application

Section I: Face Sheet

Patient Demographics

Patient Name (First, Last, Middle Initial): _____

Gender: ☐Male ☐Female ☐Transgender ☐Does not identify **Age:** _____ **DOB:** _____

Social Security Number: _____

Race/Ethnicity: ☐Asian ☐Caucasian/White ☐African American/Black ☐Hispanic/Latino

☐Native American ☐Other, please specify_____

Sexual Orientation: ☐Heterosexual ☐Homosexual ☐Bisexual ☐None

Marital Status: ☐ Never Married ☐Single ☐Divorced ☐Separated ☐Widow

If Married, Spouse Name: _____

Highest Level of Education: ☐K ☐ 1st ☐2nd ☐3rd ☐4th ☐ 5th ☐6th ☐7th ☐8th ☐9th ☐10th
☐11th ☐12th ☐GED ☐Some College ☐Associates Degree ☐Bachelor's Degree
☐ Master's Degree ☐Doctoral Degree

Home Address: _____

City: _____ **State**: _____

Zip Code: _____ **Phone Number:** _____

Email Address: _____

Religious Affiliation: _____

Employment: ☐Employed ☐Unemployed

Section II: Emergency Contact Information

Name (First, Last, Middle Initial): _____

Address: _____ **Relationship to Patient:** _____

_____ **City:** _____

Zip Code: _____ **State:** _____

Email: _____ **Home Phone:** _____

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Section III: Medical History

Do you currently: Smoke? ☐Yes ☐No If Yes, How Much? _____

Drink? ☐Yes ☐No If Yes, How Much? _____

Use Drugs? ☐Yes ☐No If Yes, How Much and what type?_____

_____

Please List All Prescriptions and Dosages:

_____

_____

_____

Please List Any Allergies:

_____

_____

Please List Any Current Medical Conditions:

_____

_____

Are you currently under a doctor's care? ☐Yes ☐No

If Yes, Why? _____

Primary Care Doctor: _____ Phone Number: _____

City: _____ State: _____

Have you Ever Been Hospitalized for a Physical Illness or injury? ☐Yes ☐No

If Yes, When, Where and Why?

_____

_____

Have you Ever Been Hospitalized for a Mental Illness? ☐Yes ☐No

If Yes, When, Where and Why?

_____

_____

_____

Have you Ever Had Any Kind of Mental Health Therapy? ☐Yes ☐No

If Yes, When, Where and Why?

_____

_____

_____

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Section IV: Insurance Information

☐**Self-Pay**
☐**EAP**
☐**I do have health insurance** **(list insurance information below)**
☐**I do not have health insurance and would like to apply for CCCS sliding scale fee**

Insurance Provider: _____ Policy Number: _____

Primary Subscriber Name: _____ Group Number: _____

Relationship to Patient: _____ Home Phone: _____

Primary Subscriber Address: _____
(List Full Street Address)

Secondary Insurance -If Applicable

Insurance Provider: _____ Policy Number: _____

Primary Subscriber Name: _____ Group Number: _____

Relationship to Patient: _____ Home Phone: _____

Primary Subscriber Address: _____
(List Full Street Address)

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Section V: Signature(s)

I, _____ guarantee that the information given on this admission application is accurate as possible and any information that is discrepant and/or conflicting with medical necessity, such as information that is not given or is not completely specified as presented by myself may lead to the discharge from Clinical Counseling and Consulting Services, PLLC.

Patient Signature: _____ **Date**: _____

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ASSESSMENT AND TREATMENT CENTER

Authorization for Assessment/Evaluation

☐**Comprehensive Clinical Assessments** - are conducted for a variety of reasons, including diagnostic clarification, qualification for services, and treatment/support recommendations. A Comprehensive Clinical Assessment is an intensive clinical and functional face-to-face evaluation of an individual's presenting mental health, developmental disability, and/or substance abuse condition that result in the issuance of a written report. **Patient Initials_____**

☐**Psychosexual Evaluation** - is an intensive clinical and functional face-to-face evaluation of an individual's sexual development, sexual history, paraphilic interests, sexual adjustment and recidivism risk level. This specialty evaluation is conducted in three sessions and utilizes various measures that are transcribed and analyzed within the assessment by the assessor. **Patient Initials_____**

☐**Addictions Evaluation** - is an intensive clinical and functional face-to-face evaluation that determines if the individual has a drug or alcohol addiction. The evaluation assesses the extent of the substance use or addiction, distinguishes co-occurring conditions, including any physical or mental health concerns, or any other drug use, evaluates the extent by which the substance use affects the individual's life and provides an understanding of the person and their circumstances. **Patient Initials_____**

☐**Trauma Assessment** - is an intensive clinical and functional face-to-face evaluation that measure the types of trauma an individual has been exposed to, or the degree of severity of the traumatic event the individual has experienced. The assessment assesses for a wide range of traumatic events, risk behaviors, functional impairments, and developmental derailments. The assessment determines origin of trauma in regard to developmental stages. **Patient Initials____**

☐**Autism Evaluation** - is an intensive clinical and functional face-to-face assessment that is based on the individual's strengths and interests. The assessment describes the core and associated deficits of Asperger's Disorder and how those deficits impact the individuals functioning. This evaluation utilizes that determine the existence of Autistic Disorder and appropriate course of treatment. **Patient Initials____**

Informed Consent: The overall duration of all assessments and evaluations depend on the nature of the assessment/evaluation. There can be no guarantees about the outcome of any type of assessment/evaluation. Additionally, the assessment and evaluation process may involve discussing unpleasant aspects of one's life and may lead to unanticipated results and/or conclusions that may be discomforting. I understand that Clinical Counseling and Consulting Services, PLLC attempts to minimize these risks by thoroughly reviewing the nature and purpose of the assessment/evaluation with me and explaining the results in language that I can understand. I authorize, consent, and request that my treating provider administer the above checked assessment/evaluation(s). I understand that the purpose of these procedures and that the assessment/evaluation process is designed to be helpful, it may at times be difficult and uncomfortable **Patient Initials_____**

Confidentiality: We maintain strict and firm policy of confidentiality about your personal information and matters related to your treatment. No information about you or your family will be given to another individual or agency without your written authorization. The only exception includes life-threatening emergencies, a court subpoena of records, or instances involving our ethical and legal duty to report abuse of children, elder adults, or disabled individuals. I understand in all cases any personal identifying information will not be used without my written permission. **Patient Initials_____**

Signatures

My signature below indicates that I have read and understand the items listed above. I am acknowledging that I agree with the information presented within, and by initialing the statements above, agree to each item as indicated.

_____ _____

Patient Signature **Date**

_____ _____

Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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ASSESSMENT AND TREATMENT CENTER

Informed Consent and Authorization for Psychological Evaluation

Through the administration the psychological evaluation, you have the right to inquire about the nature or purpose of all tests and procedures. You also have the right to know the test results, interpretations, and recommendations. The evaluation generally begins with an informational interview followed by the administration of one or more psychological or educational tests. Although it is sometimes possible to complete the testing in one sitting, it is common for the evaluation to require two or three several-hour sessions.

Types of Evaluations

- *Full Psycho-Educational Evaluation* – The purpose of this evaluation is to provide an in-depth study of the cognitive/intellectual processes and current academic levels of functioning. This evaluation might also include an assessment of memory and executive functioning.
- *Psychodiagnostic Evaluation* -- The purpose of this is to evaluate for behavioral or emotional factors such as Attention Deficit/Hyperactivity Disorder, depression, or anxiety disorders that may be affecting one's functional abilities.

Types of Measures

- *Diagnostic Interview and Developmental History* – to obtain information about the client outside of the testing situations, and to obtain a comprehensive history in order to make a more reliable diagnosis.
- *Cognitive Testing* – to assess overall intellectual ability, as well as strengths and weaknesses in areas such as verbal comprehension, perceptual reasoning, working memory, and processing speed.
- *Achievement Testing* – evaluation of academic abilities in the areas of word reading, phonics, reading comprehension, written language, math reasoning, calculation, and academic fluency. Measures of oral
- language may also be assessed.
- *Attention and Executive Functioning assessment* – to assess attentional processes, along with any difficulties pertaining to initiation, sustained effort, emotional modulation, ability to monitor and self-correct, working memory, organization, and planning.
- *Behavior Rating Scales and/or on-site behavioral observation* at school in order to get a sample of behaviors outside of the office setting.
- *Interviews* with teachers, family members, or other relevant individuals. Such interviews will only be conducted with specific written consent.

Feedback

The type(s) of feedback you and/or your child will receive may include:

- A comprehensive written report that provides findings for each measure, an integrated summary, and recommendations for accommodations, interventions or treatment.
- A brief, written summary that provides an overview of findings and recommendations.
- In-person or telephone interpretive feedback session.

Informed Consent: The overall duration of all assessments and evaluations depend on the nature of the evaluation. There can be no guarantees about the outcome of any type of evaluation. Additionally, the assessment and evaluation process may involve discussing unpleasant aspects of one's life and may lead to unanticipated results and/or conclusions that may be discomforting. I understand that Clinical Counseling and Consulting Services, PLLC attempts to minimize these risks by thoroughly reviewing the nature and purpose of the evaluation with me and explaining the results in language that I can understand. I authorize, consent, and request that my treating provider administer the above checked evaluation(s). I understand that the purpose of these procedures and that the evaluation process is designed to be helpful, it may at times be difficult and uncomfortable**. Patient/Legal Responsible Person Initials_____**

Confidentiality: We maintain strict and firm policy of confidentiality about your personal information and matters related to your treatment. No information about you or your family will be given to another individual or agency without your written authorization. The only exception includes life-threatening emergencies, a court subpoena of records, or instances involving our ethical and legal duty to report abuse of children, elder adults, or disabled individuals. I understand in all cases any personal identifying information will not be used without my written permission. **Patient/Legal Responsible Person Initials_____**

Signatures

My signature below indicates that I have read and understand the items listed above. I am acknowledging that I agree with the information presented within, and by initialing the statements above, agree to each item as indicated.

_____ _____

Patient Signature **Date**

_____ _____

Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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Patient Orientation Acknowledgement

As a patient of Clinical Counseling and Consulting Services, PLLC (CCCS), I acknowledge that during patient orientation I have been explained and given written materials regarding:

- ☐ Patient Rights and Responsibilities
- ☐ Admission
- ☐ Discharge
- ☐ Treatment Termination
- ☐ Professional Records
- ☐ Professional Boundaries
- ☐ Litigation Limitations
- ☐ Contacting Your Therapist
- ☐ Crisis/Emergencies
- ☐ Electronic Communication
- ☐ Confidentiality
- ☐ Notice of Privacy Practices
- ☐ Notice of Disclosure without Consent
- ☐ HIPPA Authorization
- ☐ Provider Choice
- ☐ Assessment/Evaluation
- ☐ Psychotherapy
- ☐ Consent for Treatment
- ☐ Informed Consent for Treatment
- ☐ Telehealth
- ☐ Insurance
- ☐ Cancellation and Late Arrival
- ☐ Complaints and Appeals
- ☐ Treatment Planning
- ☐ Treatment Outcomes
- ☐ Coordination of Care
- ☐ Infection Control

I acknowledge that I have completed patient orientation with CCCS and that I fully understand the aforementioned contents. I acknowledge that I have been given a copy of CCCS patient orientation handbook.

_____ _____

Patient Signature **Date**

_____ _____

Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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Patient Orientation Acknowledgements and Consents

Patient Rights

I acknowledge that Clinical Counseling and Consulting Services, PLLC has provided me with a copy of my bill of rights that at minimum guarantee the security of my information, fair treatment, and autonomy over treatment decisions. **Patient Initials**: _____

Patient Responsibilities

I acknowledge that Clinical Counseling and Consulting Services, PLLC provided me with a copy my patient responsibilities that include providing accurate and complete information about my presenting issue, mental health and medical history, medications and other matters relating to my health. I acknowledge that have read, understand, and received a copy of my bill of rights and patient responsibilities from Clinical Counseling and Consulting Services, PLLC. **Patient Initials**: _____

Crisis/Emergencies

I acknowledge that my therapist may not always be immediately available to address emergent concerns. I understand that in case of crisis, I can call and/or text **EMERGENCY** to Clinical Counseling and Consulting Services, PLLC afterhours crisis line at **910-745-7065**. I understand that If I am at risk of harm to myself or someone else, I should call 911, and/or go to the nearest hospital emergency room, or call Cape Fear Valley Behavioral Health at **910-609-4000**. **Patient Initials**:_____

Electronic Communications

I acknowledge that I have read and understand the policy regarding communication with (both to/from) Clinical Counseling and Consulting Services, PLLC and/or my individual therapist via electronic methods. **Patient Initials**: _____

Signatures

My signature below indicates that I have read, understand, and received a copy of the items listed above. I am acknowledging that I agree with the information presented within, and by initialing the statements above, agree to each item as indicated.

_____ _____

Patient Signature **Date**

_____ _____

Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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ASSESSMENT AND TREATMENT CENTER

Patient Orientation Acknowledgements and Consents

Confidentiality

I acknowledge that confidentiality of all communications between myself and assigned therapist is protected by law. I acknowledge that contents of all services that I receive from Clinical Counseling and Consulting Services, PLLC are considered confidential and both verbal information and written records cannot be shared with another party without my written consent. I acknowledge that there are a number of exceptions that may limit confidentiality, such as my therapist's duty to warn and protect. I understand If I inform my therapist of intent or plan of harming myself, someone else, or if I report abuse of a minor or vulnerable (disabled and/or elderly) person by myself or someone else, my therapist is obligated to contact the local authorities. I understand that the local authorities may be the local police and/or department of social services. I acknowledge, accept, and understand my therapist's duty to warn and protect which limits confidentiality between me and my therapist. **Patient Initials**:_____

Other exceptions that limit Confidentiality

Confidentiality information may be released without consent: Under court order, to an internal consumer advocate; when the client has left a 24-hour facility and appropriate individuals need to be notified; and suspected abuse/neglect or communicable disease; to the client's attorney representing the State if the client is facing court hearing; to department of corrections if the client is or has been imprisoned; for the purposes of filing petition for involuntary commitment or adjudication of incompetence; to the agency's attorney; when there is imminent danger to the health, safety of the client or another client or when there is the likelihood of the commitment of a felony or violent misdemeanor; to health care provider who is providing emergency services; to another NC MH/DD/SA facility, provider of support services, Secretary, physician or other clients when necessary to coordinate appropriate and effective care: for approved research and planning, audits and statistical purposes. I understand other exceptions that limit confidentiality. **Patient Initials**:_____

Signatures

My signature below indicates that I have read, understand, and received a copy of the items listed above. I am acknowledging that I agree with the information presented within, and by initialing the statements above, agree to each item as indicated.

_____ _____

Patient Signature **Date**

_____ _____

Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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Patient Orientation Acknowledgements and Consents

HIPAA Notice of Privacy Practices

I acknowledge that I have read, understand, and have received a copy of Notice of Privacy Practices for Clinical Counseling and Consulting Services, PLLC. **Patient Initials**: _____

Notice of Disclosure without Consent

I acknowledge that I have read, understand, and have received a copy of Clinical Counseling and Consulting Services, PLLC Notice of Disclosure without Consent. **Patient Initials**: _____

HIPPA Authorization

I acknowledge that Clinical Counseling and Consulting Services, PLLC uses HIPPA authorizations to allow covered entities to engage in my treatment. I acknowledge that Clinical Counseling and Consulting Services, PLLC does not release any part of my record to any entity, other than when subpoenaed to do so by law. I understand that if I would like a copy of my protected health information (PHI) given to another provider or entity, I would have to obtain a hardcopy of the PHI from Clinical Counseling and Consulting Services, PLLC in person to distribute to the provider and/or entity. I acknowledge that this also applies to any minor that may be in my legal custody who is receiving services from Clinical Counseling and Consulting Services, PLLC. **Patient Initials**: _____

Provider Choice

I understand that I have the right to choose providers of care, such as medical physician and/or psychotherapist. I understand that If I desire to choose a different provider at any point in treatment, Clinical Counseling and Consulting Services, PLLC will assist with the referral process without threat or repercussion. I acknowledge that this also applies to any minor that may be in my legal custody who is receiving services from Clinical Counseling and Consulting Services, PLLC. **Patient Initials**: _____

Insurance Acknowledgement

I understand that if I have no insurance I am required to self-pay. I understand that if I have insurance, I may be responsible for a copay, if applicable. I also understand if I have Medicaid benefits my minimum payment is zero for authorized visits and services. I agree to notify Clinical Counseling and Consulting Services, PLLC immediately when there is a change in my insurance coverage or county of residence. I understand that if there is a termination of my insurance or payment of services for any reason, Clinical Counseling and Consulting Services, PLLC may be unable to continue rendering services. **Patient Initials**: _____

Signatures

My signature below indicates that I have read, understand, and received a copy of the items listed above. I am acknowledging that I agree with the information presented within, and by initialing the statements above, agree to each item as indicated.

_____ _____

Patient Signature **Date**

_____ _____

Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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ASSESSMENT AND TREATMENT CENTER

Patient Orientation Acknowledgements and Consents

Consent for Treatment

I authorize and request that Clinical Counseling and Consulting Services, PLLC administer mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I acknowledge that the purpose of these procedures will be explained to me upon my request and subject to my written consent. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable I acknowledge that this consent is truly voluntary and is valid until revoked. I understand that I may revoke this consent at any time and that my involvement in therapy is completely voluntary. I, do hereby seek and consent to take part in psychotherapy and assessment/evaluation services provided by Clinical Counseling and Consulting Services, PLLC. I understand that no specific promises have been made to me by this agency/therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.
Patient Initials:_____

Emergency Medical Care Consent

In the event of an emergency, I authorize Clinical Counseling and Consulting Services, PLLC to seek emergency care from hospital or a licensed emergency medical professional for me as deemed necessary. I understand that Clinical Counseling and Consulting Services, PLLC will try to reach the legally responsible person and/or individuals listed on the Emergency Contact List as quickly as possible in an emergency situation. I agree not to hold Clinical Counseling and Consulting Services, PLLC liable for any results from the provision of transportation or medical coordination. **Patient Initials**:_____

Informed Consent for Treatment

I acknowledge that unanticipated outcomes of treatment are possible in any treatment setting. I understand that Clinical Counseling and Consulting Services makes every effort to ensure client safety and avoid unanticipated outcomes, there are risks involved in mental health treatment. I understand that unanticipated outcomes include serious incidents such as reporting by staff of abuse, neglect, or exploitation; reporting by staff of illegal activity; and temporary increase in symptoms. I acknowledge the possibility of unanticipated outcomes and authorizing Clinical Counseling and Consulting Services, PLLC to provide mental health treatment, assessment, emergency treatment (including medical, surgical, psychiatric, or psychological) and evaluations or continuing care which in the opinion of the agency is deemed necessary to the well-being of myself (the patient) and/or my child (as a patient). **Patient Initials**:_____

Signatures

My signature below indicates that I have read, understand, and received a copy of the items listed above. I am acknowledging that I agree with the information presented within, and by initialing the statements above, agree to each item as indicated.

_____ _____
Patient Signature **Date**

_____ _____
Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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CLINICAL COUNSELING &Consulting Services, PLLC
ASSESSMENT AND TREATMENT CENTER

Patient Orientation Acknowledgements and Consents

Consent with Primary Care Physician

I hereby request and authorize Clinical Counseling and Consulting Services, PLLC to exchange (receive and disclose) my individually identifiable health information as specified below.

REDISCLOSURE: Once information is disclosed as authorized below, I understand that the federal health privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

Name of Practice Entity:	Purpose:	Information to be Disclosed:
	Service coordination	Assessments, treatment plan, health related treatment information, clinical summaries, discharge summary

I understand that the information to be released may include information regarding Drug and Alcohol Abuse, Medical Conditions, Psychological and/or Psychiatric Impairments, and Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV). I also understand that any provider that has been previously granted access to my electronic information will continue to have access until that previous authorization expires or is revoked in writing as explained below.

I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my child's ability to receive treatment. I understand that any revocation of this authorization will need to be put in writing and will not be effective until the date it is received by Clinical Counseling and Consulting Services, PLLC. I understand I should provide the written statement to revoke the authorization to the assigned case manager.

As the legally responsible person, I have the right to request access to the contents of records pertaining myself as the patient and/or my child/adolescent as the patient, by contacting my assigned therapist at Clinical Counseling and Consulting Services, PLLC.

_____ _____

Patient Signature **Date**

_____ _____

Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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CLINICAL COUNSELING &Consulting Services, PLLC
ASSESSMENT AND TREATMENT CENTER

Patient Orientation Acknowledgements and Consents

Authorization for Disclosure

I hereby request and authorize Clinical Counseling and Consulting Services, PLLC to exchange (receive and disclose) my individually identifiable health information as specified below.

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Entity (Agency or Person):

_____

For the following purpose(s):

_____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (***Please initial beside each applicable document***) _____ Admission Assessments

_____Medications	_____ Treatment Plans	_____Treatment Recommendations
_____ Psychiatric Evaluations	_____ Psychological Evaluations	_____ Progress/Psychotherapy Notes
_____Discharge Summaries	_____Aftercare Plans/Orders	_____ Lab Results
_____Alcohol/Drug Treatment	_____AIDS/HIV	

_____ Other: _____

I understand that the information to be released may include information regarding Drug and Alcohol Abuse, Medical Conditions, Psychological and/or Psychiatric Impairments, and Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV). I also understand that any provider that has been previously granted access to my electronic information will continue to have access until that previous authorization expires or is revoked in writing as explained below.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my child's ability to receive treatment. I understand that any revocation of this authorization will need to be put in writing and will not be effective until the date it is received by Clinical Counseling and Consulting Services, PLLC. I understand that I should provide this written statement to revoke the authorization to the assigned case manager.

As the legally responsible person, I have the right to request access to the contents of records pertaining myself as the patient and/or my child/adolescent as the patient, by contacting my assigned therapist at Clinical Counseling and Consulting Services, PLLC.

_____ _____

Patient Signature **Date**

_____ _____

Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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CLINICAL COUNSELING & Consulting Services, PLLC
ASSESSMENT AND TREATMENT CENTER

Patient Orientation Acknowledgements and Consents

Authorization for Disclosure

I hereby request and authorize Clinical Counseling and Consulting Services, PLLC to exchange (receive and disclose) my individually identifiable health information as specified below.

REDISCLOSURE: Once information is disclosed as authorized below, I understand that the federal health privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

Entity (Agency or Person):

_____

For the following purpose(s):

_____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (***Please initial beside each applicable document***) _____ Admission Assessments

_____Medications _____ Treatment Plans _____Treatment Recommendations
_____ Psychiatric Evaluations _____ Psychological Evaluations _____ Progress/Psychotherapy Notes
_____Discharge Summaries _____Aftercare Plans/Orders _____ Lab Results
_____Alcohol/Drug Treatment _____AIDS/HIV
_____ Other: _____

I understand that the information to be released may include information regarding Drug and Alcohol Abuse, Medical Conditions, Psychological and/or Psychiatric Impairments, and Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV). I also understand that any provider that has been previously granted access to my electronic information will continue to have access until that previous authorization expires or is revoked in writing as explained below.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my child's ability to receive treatment. I understand that any revocation of this authorization will need to be put in writing and will not be effective until the date it is received by Clinical Counseling and Consulting Services, PLLC. I understand that I should provide this written statement to revoke the authorization to the assigned case manager.

As the legally responsible person, I have the right to request access to the contents of records pertaining myself as the patient and/or my child/adolescent as the patient, by contacting my assigned therapist at Clinical Counseling and Consulting Services, PLLC.

_____ _____
Patient Signature **Date**

_____ _____
Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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Patient Demographic label HERE

3|C Clinical Counseling & Consulting Services, PLLC
Assessment and Treatment Center

Patient Orientation Acknowledgements and Consents

Authorization for Disclosure

I hereby request and authorize Clinical Counseling and Consulting Services, PLLC to exchange (receive and disclose) my individually identifiable health information as specified below.

REDISCLOSURE: Once information is disclosed as authorized below, I understand that the federal health privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

Entity (Agency or Person):

_____

For the following purpose(s):

_____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (***Please initial beside each applicable document***) _____ Admission Assessments

_____Medications _____ Treatment Plans _____Treatment Recommendations
_____ Psychiatric Evaluations _____ Psychological Evaluations _____ Progress/Psychotherapy Notes
_____Discharge Summaries _____Aftercare Plans/Orders _____ Lab Results
_____Alcohol/Drug Treatment _____AIDS/HIV
_____ Other: _____

I understand that the information to be released may include information regarding Drug and Alcohol Abuse, Medical Conditions, Psychological and/or Psychiatric Impairments, and Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV). I also understand that any provider that has been previously granted access to my electronic information will continue to have access until that previous authorization expires or is revoked in writing as explained below.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my child's ability to receive treatment. I understand that any revocation of this authorization will need to be put in writing and will not be effective until the date it is received by Clinical Counseling and Consulting Services, PLLC. I understand that I should provide this written statement to revoke the authorization to the assigned case manager.

As the legally responsible person, I have the right to request access to the contents of records pertaining myself as the patient and/or my child/adolescent as the patient, by contacting my assigned therapist at Clinical Counseling and Consulting Services, PLLC.

_____ _____
Patient Signature **Date**

_____ _____
Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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CLINICAL COUNSELING &Consulting Services, PLLC
ASSESSMENT AND TREATMENT CENTER

Patient Orientation Acknowledgements and Consents

Authorization for Student Intern

Clinical Counseling and Consulting Services, PLLC (CCCS) participates in clinical education programs with area colleges and universities to give students engaged in a course of study related to a mental health career; including social work students, counseling students, and psychology students ("interns") experience in clinical practice. CCCS has agreed to permit such interns to observe and participate in patient care activities, including, where appropriate, providing mental health treatment to patients under the licensed psychotherapist direct supervision.

☐ **I consent to student interns**

☐ **I decline student interns**

By signing below, you agree to permit the interns working with your psychotherapist to observe and participate in your mental health treatment, including, where appropriate, providing direct mental health treatment to you under your licensed psychotherapist direct supervision. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your treatment.

_____ _____

Patient Signature **Date**

_____ _____

Clinical Counseling and Consulting Services, PLLC Staff Signature **Date**

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Patient Orientation Acknowledgements and Consents

Telehealth Consent Form

Please review this agreement carefully, as it sets forth the understanding between you ("Client") and the Clinical Counseling and Consulting Services, PLLC ("Agency") regarding the services you have requested, and we will provide for you. If you have any questions, concerns or issues about the content of this Agreement please contact us for clarification before signing it.

Telehealth is the use of electronic transmissions to treat the needs of a patient. In this case, we offer both video and audio forms of communication via the Internet and/or telephone. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications, may occur from different locations geographically in order to assist with delivery of care when access to care may not be possible by face-to-face visits.

You understand that Teletherapy occurs in the state of North Carolina and is governed by the laws of the state where the client resides. Teletherapy may also be governed by the laws of the state in which the providers are located at the time of service delivery if that state is other than NC. All providers are licensed in the states in which you reside, as well as the state the provider may be located in at the time of a Teletherapy session.

While Teletherapy is an effective way to obtain assistance when geographic distance or scheduling conflicts prevent face to face care, in the event that Teletherapy is determined to not be in your best interests, your provider will explain that to you and suggest some alternative options better suited to your needs. In most cases, this will likely include a recommendation for face-to-face psychiatric consultation or psychotherapy or a referral to a facility or an agency that may provide a higher level of care. Teletherapy is not intended for emergency services, and if emergencies arise you will be required to seek face to face consultation and evaluation, and by signing this consent, you agree in advance to seek such care if you or your provider deem this necessary. In the event of an imminent emergency, clients should consult the nearest emergency room or psychiatric facility to provide emergent care.

You are responsible for information security on your computer. If you decide to keep copies of our emails or other communication on your computer, it's up to you to keep that information secure. Unfortunately, we cannot guarantee the security of emails as they travel between computers. It is possible, though unlikely, to intercept emails in transit.

You release the Clinical Counseling and Consulting Services, PLLC from any liability in the event that teletherapy is not secure and confidential as reported by the manufacturer. The software of choice by the Clinical Counseling and Consulting Services, PLLC is preferred due to HIPAA compliance and encryption ensuring the security of transmission while Skype's fundamental security is not documented as clearly rendering Skype's degree of security uncertain at this point. Skype may be an alternative when VSee or other platforms are unavailable as a means of conducting Teletherapy.

Teletherapy may be received either from your chosen environment (e.g., home or work) or from another location of your choice. You understand that you are responsible for (1) providing the necessary computer, telecommunications equipment and internet access for Teletherapy sessions; (2) the information security on your computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions and intrusions, and sufficient for privacy to protect your personal health information.

I understand that there are risks and consequences from Teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. Other risks include Viruses, Trojans, and other involuntary intrusions that have the ability to grab and release information you may desire to keep private. Furthermore, with Teletherapy, there is the risk of being overheard by anyone near you if you do not place yourself in a private area and protected from other's intrusion. You maintain sole responsibility for ensuring the privacy of your surroundings if participating in Teletherapy. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy and that despite my provider's efforts, my condition may not improve, and in some rare cases may even get worse.

Consent to Contact and Electronic Transmittal

I give my consent for the Clinical Counseling and Consulting Services, PLLC to send by electronic transmittal (fax or email) or communicate by cellular phone, with appropriate release of information, confidential information concerning my or my child's diagnosis, care, testing records, admission, treatment plan and goals. I have the right to revoke this authorization at any time. Revocation is not effective in cases where the information has already been disclosed but will be effective in moving forward.

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I am fully aware that electronic transmittal, wireless telephone communication, and web-based systems are subject to difficulties and that the Clinical Counseling and Consulting Services, PLLC cannot and does not guarantee the confidentiality of such technology.

I understand the Clinical Counseling and Consulting Services, PLLC will exercise all reasonable precautions and I will in no way hold the Agency liable for any difficulties resulting in me or any other family member from the communication of confidential information by means of cellular phone, fax, email or web-based scheduling systems. I have the right to refuse to sign this authorization and my treatment will not be conditioned on signing.

Consents

- Your signature indicates that you and/or your representative have read, understand and are in agreement with the terms and conditions of this agreement, including the following:
- You are the person that can provide this legal consent
- You have read this agreement and agree to its terms

I agree and consent to this Telehealth Consent Form

_____

Patient Signature/Date

I agree and consent to Electronic Transmission Consent

_____

Patient Signature/Date

_____

Clinical Counseling and Consulting Services, PLLC Representative Signature/Date

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The next page is the signature page of your treatment plan. Please sign as confirmation that you will develop this plan with your assigned therapist. Please DO NOT DATE the plan. You will date the plan with your therapist after the plan is developed.

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PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- ☐ I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- ☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- ☐ For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes ☐ No ☐

Person Receiving Services: (Required when person is his/her own legally responsible person)

Signature: _____ _____ Date: __/__/__

(Print Name)

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ _____ Date: __/__/__

(Print Name)

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: _____ _____ Date: __/__/__

(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:

- ☐ Met with the Child and Family Team - Date: __/__/__
- ☐ **OR** Child and Family Team meeting scheduled for - Date: __/__/__
- ☐ **OR** Assigned a TASC Care Manager - Date: __/__/__
- ☐ **AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

- ☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ _____ Date: __/__/__

(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: *REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.*

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- ☐ Medical necessity for services requested is present, and constitutes the Service Order(s).
- ☐ The licensed professional who signs this service order has had direct contact with the individual. ☐ Yes ☐ No
- ☐ The licensed professional who signs this service order has reviewed the individual's assessment. ☐ Yes ☐ No

Signature: _____ _____ License #: _____ Date: __/__/__

(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- ☐ CAP-MR/DD or
- ☐ Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- ☐ **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

- ☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: _____ _____ License #: _____ Date: __/__/__

(Name/Title Required) (Print Name) (If Applicable)

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