I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

Personal Information

Name:____ Date: _______________________

Parent/Legal Guardian (if under 18): ____

Address: ____

Home Phone: ___ ________________________________ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: ________________________ May we leave a message? □ Yes □ No

Email: ____ May we leave a message? □ Yes □ No **Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _______________________________ Age: _______ Gender: _________________

Martial Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Referred By (if any): ____

Mental Health History

Have you previously received any type of mental health services?

□ No □ Yes, previous therapist/practitioner: ____

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list:

____

____

Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dates:

____

____

Please list any specific sleep problems you are currently experiencing:

____

____

1. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?____

Clients Name_____________________________ Record #_____________

2. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? ____

3. Do you drink alcohol more than once a week? □ No □ Yes

4. Do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

5. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? ____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
____

6. What significant life changes or stressful events have you experienced recently:______________
____
____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_________________________
Anxiety	yes / no	_________________________
Depression	yes / no	_________________________
Domestic Violence	yes / no	_________________________
Eating Disorders	yes / no	_________________________
Obesity	yes / no	_________________________
Obsessive Compulsive Behavior	yes / no	_________________________
Schizophrenia	yes / no	_________________________
Suicide Attempts	yes / no	_________________________

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, Do you enjoy your work? Is there anything stressful about your current work? ____________________

____
____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

Clients Name______________________________ Record #______________

3. What do you consider to be some of your strengths? ______________________________________
____
____
____

4. What do you consider to be some of your weaknesses? ____________________________________
____
____
____

5. What would you like to accomplish out of your time in therapy? ____________________________
____
____

Clients Name____________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

CLIENT FACE SHEET

Admission Date:_______________________________________ Record #_______________________________

Status: New ☐ Returning ☐

Phone________________________ Birthplace____________________ Race____________________________

Gender_______________________ Veteran Yes ☐ No ☐

Address____

Marital Status_______________________ Children Yes ☐ No ☐

Custody Yes ☐ No ☐ # In Household_________ Step-Children: _Yes or No____________

Emergency Contact____________________________________ Phone_________________________________

Address ____

Emergency Contact____________________________________ Phone_________________________________

Address ____

Last Grade Completed______________________ Current School_____________________________________

DSS/Court Involvement Yes ☐ No ☐

Legal History____

Employed Yes ☐ No ☐

Employer Name____

Suicidal Ideation Present No ☐ Yes ☐

Suicidal Ideation Means No ☐ Yes ☐

Suicidal Ideation Plan No ☐ Yes ☐

Suicidal Ideation Intent No ☐ Yes ☐

Reason for Referral____

Staff Signature____ Date ____________________________

Client Signature____ Date ____________________________

Clients Name_____________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

Baseline Measurements: Indicate Baseline Scores Below					
	(5) = Critical	(4) = Very Problematic	(3) = Moderately Problematic	(2) = Mildly Problematic	(1) = No Problem
Activities of Daily Living	☐	☐	☐	☐	☐
Aggression/Impulsivity/Recklessness	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Depression/Mania	☐	☐	☐	☐	☐
Job/School Problems	☐	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	☐
Risk to Others	☐	☐	☐	☐	☐
Risk to Self	☐	☐	☐	☐	☐
Social/Relationships/Marital/Family Problems	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐

H/S Risk Assessment					
	Low Lethality				High Lethality
PLAN ☐ None	☐ none/vague or indeterminate plan	☐ Clear thoughts, philosophical	☐ Some specifics to plan	☐ Note &/or well thought out, written	☐ Note written &/or time, place, method chosen
METHOD ☐None	☐ Not applicable /Method undecided	☐ Method: pills, cutting	☐Method: overdose, oven gas, car	☐ Method: hanging, jumping	☐ Method: Gun
AVAILABILITY ☐ None	☐ Method unavailable	☐ Can acquire easily	☐ some effort equired to prepare	☐ Method ready, in the home	☐ Method in hand
TIME ☐ None	☐ No time specified	☐ Specified vaguely, within weeks	☐ Day and time chosen within a week	☐ Plan to complete today	☐ Plan in progress
PRIOR ATTEMPT ☐None	☐ None	☐ 1 or 2 gestures	☐ History of many threats or attempts	☐ History of highly lethal attempt	☐ Over 2 past serious attempts
DEPRESSION ☐None	☐ feeling low or blue”	☐ mild depression	☐ Chronic depression	☐ Major depression	☐ Major depression + hopelessness
PSYCHOSIS ☐ None	☐ None or fully ontrolled by nedication	☐ mild visual or auditory hallucinations	☐ upsetting visual/ auditory hallucination or mild delusion	☐ significant hallucinations and/or delusions	☐ command hallucinations
RECENT LOSSES or STRESSORS ☐	☐ None	☐ 1 minor conflict or loss	☐ Several concurrent stressors/losses	☐ Major loss or conflict	☐ Several significant losses/changes
HEALTH ☐None	☐ physically healthy	☐ transitory illness	☐disability or chronic health problems	☐ severe illness or injury, recent diagnosis	☐ terminal illness, recent diagnosis
ISOLATION ☐ None	☐ Others present and supportive	☐ Roommate or significant other present	☐ Others close by	☐ Alone, at home, no help nearby	☐ Alone, rented room or car, isolated
HISTORY OF VIOLENCE ☐	☐ None	☐ self-directed (e.g. cutting, PICA)	☐ previous violence toward others	☐ previous violence with family members	☐ previous use of weapons
COMORBIDITY ☐None	☐ no presence of predictors listed below	☐ 1 predictor present	☐ more than 1 factor present	☐ long term existence of several factors	☐ suicidal careers

Staff Signature____ Date ____________________________

Client Signature____ Date ____________________________

Clients Name_____________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

CLIENT FACE SHEET

Primary Care Doctor_________________________ Phone Number:___________________________________

Address___________________________________ Fax Number:_____________________________________

Secondary Doctor_________________________ Phone Number:___________________________________

Address___________________________________ Fax Number:_____________________________________

Insurance:____ Policy #:_____________________________

Medical Condition:____
____
____

Current Medication:____
____
____

Allergies or Sensitivities:____

Case Manager:__________________________ Phone #:____

Primary Physician:_______________________ Phone #:____

Psychiatrist:____________________________ Phone #:____

I, ____________________, grant permission to obtain necessary medical treatment in the case of illness or an accident. I authorize a representative of I Do Care Counseling & Consulting Services, PLLC. to act on my behalf in the case of an emergency with a diligent effort to notify the next of kin of guardian has been made. I further acknowledge that I may revoke this consent at any time except to extent that the action based on this consent has been taken.

Client Signature: ____ **Date:** __________________________

Legally Responsible Person/Guardian:________________________________ **Date:**__________________________

I Do Care Counseling, PLLC_________________________ __________**Date:**______________________________

Clients Name______________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

ACKNOWLEDGEMENT OF PROVIDER CHOICE

I understand that I Do Care Counseling & Consulting Services, PLLC. is required to ensure that services provided are deemed medically necessary. I have been informed of my right to choose a provider from a list of service providers provided by my insurance co or referring department. I have been additionally informed of my right to change providers at a later date in my treatment.

_______________ I alone have made the decision for I Do Care Counseling & Consulting Services, PLLC. to render my services, nor did personnel from I Do Care Counseling & Consulting Services, PLLC. influence my decision.

_______________ I have chosen I Do Care Counseling & Consulting Services, PLLC. as my contract provider for Outpatient Services.

_______________ Emergency choice made ____Date:___________________

I Do Care Counseling & Consulting Services, PLLC. explanation for denial/ emergency choice:

____

____

____

____

____

Client Signature: ____ **Date:** _____________________________

Legally Responsible Person/Guardian:__________________________________ **Date:**_____________________________

I Do Care Counseling, PLLC____________________________ __________**Date:**________________________________

Clients Name_________________________________ Record #_______________

ATTENDANCE CONTRACT

In order to maximize the benefits of therapy, it is very important that all scheduled appointments be attended. The consistency of attending therapy sessions assures that you will obtain maximum treatment benefits, and assist in meeting your goals. “I Do Care Counseling & Consulting Services, PLLC” anticipate that you will adhere to the following:

1. I understand that any appointment missed for any reason that is not rescheduled that same week is considered an absence. Two times tardy for therapy equals an absence.
2. I understand that missing three scheduled therapy appointments in a three month period is grounds for discharge from therapy. If I must cancel the appointment due to an illness or emergency, I will contact the office as soon as possible. Family emergencies will be taken into consideration.
3. I agree to call to cancel my appointments at least 24 hours in advance. If I do not call to cancel and do not attend therapy, this will be considered a “no-show.”
5. I understand that if I arrive fifteen minutes late, I may not receive therapy that day, depending on what the therapist had planned for that session (i.e. procedures that require a full hour to complete)
6. I agree to notify the therapist at least two weeks in advance of vacations or extended leave of absence for the duration of my scheduled treatment sessions.
7. I understand that if my regular therapist is not available, I will be given the option to see another therapist. If one is available.

Following these guidelines will greatly facilitate quality of treatment. Thank you for your cooperation.

Client Signature: ____ **Date:** ___________________________

Legally Responsible Person/Guardian:________________________________ **Date:**___________________________

I Do Care Counseling, PLLC__________________________ __________**Date:**______________________________

Clients Name______________________________ Record #______________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

MEMBER'S RIGHTS

I, ____, have been given a copy by I Do Care Counseling & Consulting Services, PLLC of my member's rights and I understand my right as a member of services.

Client Signature: ____ Date: __________________

Legally Responsible Person/Guardian:____________________________ Date:__________________

I Do Care Counseling, PLLC_______________________ _________Date:___________________________

Clients Name___________________________ Record #____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

HIPAA

PROTECTING THE PRIVACY OF MEMBER'S HEALTH INFORMATION

GLOSSARY OF HIPAA TERMS

Disclosure- Means the release transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.

HIPAA- Health Information Portability and Accountability Act. Public Law 104- 191 is the law that protects the privacy and security of health information.

Protected Health Information – Individually Identifiable health information that is transmitted or maintained in any form. This excludes education records and employment records held by covered entity in its role as an employer.

HIPAA- Federal privacy standards to protect member's medical records and other health information provided to health plans, doctors, hospitals, and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (DHHS), these new standards provide the member with access to their medical records and more control over how their personal health information is used and disclosed.

Congress called on DHHS to issue member privacy protections as part of the Health Insurance Portability and Accountability Act of 1196 (HIPAA). HIPAA included provisions designed to encourage electronic transactions and also required new safeguards to protect the security and confidentiality of health information. Congress included provisions in HIPAA to protect the privacy and security of that information.

Privacy: The privacy provides a comprehensive framework of the rules for the protection of identifiable health information in any form or medium (including paper, electronic and oral). The regulation also creates a series of new individual rights that all members have with respect to their health information, such as, the right to a notice of private practices, the right to inspect, copy and amend health information and the right to a disclosure history.

Civil and Criminal: Congress provided civil and criminal penalties for covered entities that misuse personal health information. For civil violations of the standards, OCR may impose monetary penalties up to $100 per violation, up to 25,000 per year for each requirement or prohibition violated. Criminal penalties can range up to $50,000 and one year in prison for certain offenses committed under "false pretenses"; and up to $250,000 and up to 10 years in prison if the offenses are committed with the intent to sell, transfer or use protected health information for commercial advantage, personal gain, or malicious harm.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is the federal law that protects your private health information. The HIPPA law states that medical records, treatment plans and any other information about you (including what you say or share) must be kept private. Anyone not involved in providing your care, including family members, must first obtain your or your guardian's permission before this information is provided to them.
If any employee violates HIPPA regulations, the agency could be held for monetary compensations and you, the employee could be terminated from your position.

I Do Care Counseling, PLLC__________________________ __________Date:_____________________________

Client Signature: ____Date: ________________________

Clients Name______________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have and received and reviewed a copy of the HIPPA Notice of Privacy Practices for I Do Care Counseling & Consulting Services, PLLC.

My rights with respect to my personal healthcare information have been fully explained to me and I understand when and how my healthcare information may be used and/ or disclosed. Also, I understand how and where to file a complaint related to violations of my privacy, I relate to my personal healthcare information.

I further understand that if the term of this notice should change in the future, I will be notified in writing and can request a copy of the notice by contacting I Do Care Counseling & Consulting Services, PLLC.

Client Signature: ____ Date: ___________________________

Legally Responsible Person/Guardian:________________________________ Date:___________________________

I Do Care Counseling, PLLC__________________________ __________Date:______________________________

Please provide an explanation if the signature of the member or legally responsible person is not obtained.

____

____

____

Clients Name______________________________ Record #______________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

INDIVIDUAL RIGHTS FACT SHEET

Individuals receiving services have:

- The right to be treated with respect and recognition of your dignity and right to privacy.
- The right to be free from any form of restraint or seclusion used as a means of coercion discipline, convenience or retaliation.
- The right to equal employment and educational opportunity.
- The right to participate in the development of a written person centered treatment plan that builds on individual needs, strengths and preferences. A treatment plan must be implemented within 30 days after services start.
- The right to freedom of speech and freedom of religious expression.
- The right to treatment in the most natural, age-appropriate and least restrictive environment possible.
- The right to ask questions when you do not understand your care or what you are expected to do.
- The right to NC formerly Governors Advocacy Council for Persons with Disabilities 1-877-235-4210.
- The right to be treatment regardless of gender, color, national origin, sexual orientation, religious preference, and a level of disability.
- The right for staff to seek emergency care on your behalf if there is a medical or psychiatric emergency.
- The right to receive information about Sandhills Center, its services, its providers/practitioners, and member rights and responsibilities presented in a manner appropriate to your ability to understand.
- The right to participate with I Do Care Counseling & Consulting Services, PLLC in making decisions about your health care.
- A right to a candid discussion with I Do Care Counseling & Consulting Services, PLLC on appropriate or medically.
- necessary treatment options for your condition, regardless of cost or benefit coverage. I Do Care Counseling & Consulting Services, PLLC, may need to decide among relevant treatment options, the risks, benefits, and consequences, including your right to refuse treatment and to express your preferences about future treatment decisions regardless of benefit coverage limitation.
- If I Do Care Counseling & Consulting Services, PLLC request for approval of a service is denied, you have the right to file an appeal for further consideration or re-consideration of the matter.
- A right to voice complaints or appeals about Sandhills Center or the care it provides.
- A right to make recommendations regarding Sandhills Center’s member rights and responsibilities policy.

Clients Name______________________________ Record #_____________

INDIVIDUAL RIGHTS FACT SHEET (CONTINUED)

- A responsibility to supply information (to the extent possible) that Sandhills Center and I Do Care Counseling & Consulting Services, PLLC need in order to provide care.
- A responsibility to follow plans and instructions for care that you have agreed to with I Do Care Counseling & Consulting Services, PLLC.
- A responsibility to understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- The right to request and receive a copy of your medical record subject to therapeutic privilege set forth in NC G.S. 1224-C.53(c) and to request that the medical record be amended or corrected in accordance with 45 C.F.R. Part 164 and the provisions of NC G.S. 1224-C.53(c). If the doctor or therapist determines that this would be detrimental to your physical or mental wellbeing, they can request that the information be sent to a physician or professional of their choice.
- The right to take part in the development and periodic review of your treatment plan and to consent to treatment goals in it.
- The right to treatment with regard to gender, color, national origin, sexual orientation, religious preference, and a level of disability.
- The right for staff to seek emergency care on your behalf if there is a medical or psychiatric emergency.
- The right to file complaints or grievances.

Client Signature: ____ Date: ___________________________

Legally Responsible Person/Guardian:________________________________ Date:___________________________

I Do Care Counseling, PLLC__________________________ __________Date:______________________________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

NOTICE OF RECEIPT OF PRIVACY PRACTICES FOR I DO CARE COUNSELING & CONSULTING SERVICES, PLLC.

I acknowledge that I have been informed about the Notice of Privacy Practice for I Do Care Counseling & Consulting Services, PLLC.

I understand that the Notice of Privacy Practices discusses how my personal healthcare information may be used, and/ or disclosed, my rights with respect to health information, and how and where I may file a privacy- related complaint.

I may obtain a copy of this Notice from the agency and/ or by requesting one at anytime.

I understand that the terms of this Notice may be changed in the future, and those changes will be provided for me if requested I may also request a copy of the Notice by contacting I Do Care, PLLC or Picking it up from the office.

Member/ Guardian signature indicates receipt of Notice of Privacy Procedures:

I have been given a copy of I Do Care Counseling & Consulting Services, PLLC. Notice of Privacy Practices.

Client Signature: ____Date: ___________________________

Legally Responsible Person/Guardian:________________________________ Date:___________________________

I Do Care Counseling, PLLC___________________________ __________Date:_______________________________

I DO CARE COUNSELING & CONSULTING SERVICES, PLLC USE ONLY

If acknowledgement of receipt of Notice of Privacy Practices is not obtained from the Member or and authorized person, please explain your efforts to obtain the acknowledgement and the reasons you could not obtain it:

____
____
____
____

Clients Name______________________________ Record #______________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

THERAPY CONFIDENTIALITY AGREEMENT

It has been explained to me and I understand that any information revealed in Therapy by me or anyone in the session with me and the therapy is confidential.

This information should not be discussed outside the sessions due to member's rights and respect for the member.

Client Signature: ____ **Date:** __________________________

Legally Responsible Person/Guardian:_______________________________ **Date:**__________________________

I Do Care Counseling, PLLC_________________________ __________**Date:**_____________________________

Clients Name_____________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

Client Name: ______________________________ **Date of Birth: ______________**

Child Form:

Consent to Treatment

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from [Your Organization's Name]. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling. We have out-of-state certified clinics from MN, IL and MI to serve our WI residents. Besides following the WI administrative code, they also follow their own state applicable law and regulation.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at [Your Organization's Name], and I consent to disclosure for use by [Your Organization's Name] staff for the purpose of continuity of my child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

____ ___________________

Signature of legal guardian for minor under age 18 **Date**

____ ___________________

Signature of witness **Date**

Clients Name____________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

Client Name: ______________________________ **Date of Birth: ______________**

Adult Form**:**

Consent to Treatment

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) comprehensive clinical assessment, evaluation and/or treatment by staff from I Do Care Counseling & Consulting Service, PLLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered

   Expected side effects from the treatment and/or the risks of side effects from medications (when applicable). Probable consequences of not receiving treatment. The evaluation or treatment will be conducted by psychotherapist, licensed therapist or an individual supervised by any of the professionals listed that is provisionally licensed. Treatment will be conducted within the boundaries of North Carolina Law for Professional Counseling. Each voluntarily admitted client or the client's legally responsible person (including a health care agent named pursuant to a valid health care power of attorney) has the right to consent to or refuse any treatment offered by the facility. Consent may be withdrawn at any time by the person who gave the consent. If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible. If all appropriate treatment modalities are refused, the voluntarily admitted client may be discharged. In an emergency, a voluntarily admitted client may be administered treatment.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting your daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request. For most client's waivers are offered for deductibles and co-pays.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at I Do Care Counseling & Consulting Service, PLLC and I consent to disclosure for use by I Do Care Counseling & Consulting Service, PLLC staff for the purpose of continuity of my care. Per North Carolina mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

____ ____________________
Signature of client ages 18 years or older or LRP **Date**

____ _____________________
Signature of witness **Date**

Clients Name___________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

NOTICE TO CLIENT RELATING TO CONFIDENTIALITY:

This is to notify you that state and federal laws protect the confidentiality of your information as a client in this facility and allow for release of information only with your written consent or otherwise as the law may require or permit. There may be instances *(as listed below) in which pertinent information may be disclosed without your express written consent or in assuring you receive appropriate continuing care (for example: A hospital, DSS or Public Health Issues).

*Examples of information that may be disclosed without written consent:

☒ Chart or Staff may be Subpoenaed

☒ Medical Emergency

☒ Abuse/Neglect of Child, Adult, or the Elderly

☒ Suicidal/Homicidal

Client Signature: ____ **Date:** ___________________________

Legally Responsible Person/Guardian:________________________________ **Date:**___________________________

I Do Care Counseling, PLLC__________________________ __________**Date:**______________________________

Clients Name______________________________ Record #______________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

GRIEVANCES PROCEDURE FOR CONSENT OF SERVICES

You have the right to let your concerns (grievances) about how you are being treated be known; you have a right to be told the method you can use to let your concerns (grievances) be known. This written notice is a description of how to report grieves and complaints about services you receive from I Do Care Counseling & Consulting Services, PLLC. This written notice should be given to you and/ or legal guardian before you begin receiving services from I Do Care Counseling & Consulting Services, PLLC.

Customary Procedure:

1) You and/or your legal guardian are not limited in any way in the scope, content or frequency of your grievances.

2) You and/or guardian may begin the grievance process by telling your qualified professional what your complaint is, either in person or in writing. Your qualified professional will give you a form to fill out to describe your concern(s). Make sure that you date the form.

3) Your qualified professional will review and address the complaint with the assistance of his/ her supervisor. If the complaint is about your qualified professional, the supervisor will review the situation.

4) Your qualified professional or the supervisor will provide you with a written response within (10) working days of receiving your written grievance.

5) If you disagree with the response, you may take your complaint in writing to the administrator. The administrator will review the complaint and respond to you in writing within 10 working days of when you file your grievance.

6) If you disagree with the administrator's decision you may file your complaint in writing to the area mental health agency. The area mental health agency will make the final decision and respond to you and your legal guardian in writing within ten working days of receiving your grievance.

7) Concerns that the program staff may have about the possible inappropriate use of this grievance process will be reviewed by your service planning team (which will include a neutral person, such as referring agency representative or a human rights representative) and will be addressed in your service plan.

Client Signature: ____ **Date:** ____________________________

Legally Responsible Person/Guardian:_________________________________ **Date:**____________________________

I Do Care Counseling, PLLC___________________________ __________**Date:**_______________________________

Clients Name______________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

CONSENT TO TREATMENT/EXPLANATION OF PROGRAM/INTERVENTION/TRANSPORTATION/REVIEW OF RIGHTS AND GRIEVANCES/AMENDMENTS

_________PROGRAM: After clear explanation of program structure, rules and expectations, I (We) am (are) requesting treatment for ______________________________________at I Do Care Counseling & Consulting Services, PLLC. for Outpatient Services

I hereby authorize I Do Care Counseling & Consulting Services, PLLC. to file my private insurance, Medicaid, or Major Credit Cards, Etc. and authorize all payments to be made directly to I Do Care Counseling & Consulting Services, PLLC. in accordance with set reimbursement policies. I further understand that any department of I Do Care Counseling & Consulting Services, PLLC. to satisfy any financial obligations I may have incurred. I also understand I will be responsible for the full fee for services if I have insurance coverage and refuse to allow claims to be filed by I Do Care Counseling & Consulting Services, PLLC. if I have insurance coverage and refuse to allow claims to file by I Do Care Counseling & Consulting Services, PLLC, I also understand that I am responsible for any deductibles my private insurance or other payer source may have imposed.

I understand payment is expected at the time of each visit, and if I am unable to pay the scheduled fee at each visit, a payment plan may be established for me. I agree to notify I Do Care Counseling & Consulting Services, PLLC at least 24 hours in advance if I am unable to keep an appointment in accordance with I Do Care Counseling & Consulting Services, PLLC policy. Normal hours of operation are from 9 a.m. to 6 p.m., Monday through Friday.

I hereby authorize I Do Care Counseling & Consulting Services, PLLC to release diagnostic and treatment record when required to my insurance carrier, or any other payer. This authorization shall be valid until all claims have been processed not to exceed one year from date of discharge. I have read or had explained to me by a member of I Do Care Counseling & Consulting Services, PLLC staff the above statements and fully understand my treatment and financial obligations.

Client Signature: ____ Date: ____________________________

Legally Responsible Person/Guardian:_________________________________ Date:____________________________

I Do Care Counseling, PLLC___________________________ __________Date:_______________________________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

WEAPON, VIOLENCE, ILLEGAL DRUGS

I Do Care Counseling & Consulting Services, PLLC. prohibits the use of any type of weapons illegal drugs or violence at its facility,
during sessions or while clients are being transported in any company vehicle or employees.

Client Signature: ____ **Date:** ___________________________

Legally Responsible Person/Guardian:________________________________ **Date:**___________________________

I Do Care Counseling, PLLC__________________________ __________**Date:**______________________________

Clients Name______________________________ Record #______________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Notice to Member:

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations. Generally, this program may not say to a person outside of the program that a member attends this program or disclosure any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing;
2. the disclosure is allowed by a Court Order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal Law and Regulation by this program is a crime. Suspected violation may be reported to appropriate authorities in accordance with Federal Regulations.

Federal Law and Regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal Law and Regulation do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or local authorities (42 USC 290dd-3 and 42 USC cc-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations.)

The above regulations were explained to me on this date:

Client Signature: ____ Date: ___________________________

Legally Responsible Person/Guardian:________________________________ Date:___________________________

I Do Care Counseling, PLLC__________________________ __________Date:______________________________

Clients Name______________________________ Record #_____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name ____ Date of Birth______________________________

Client Medical Record #_____________________________ Client SS # (Optional) _____________________________

I ____ hereby authorize
(Client or Personal Representative)
I Do Care Counseling & Consulting Services, PLLC 3620 Legion Rd #210 Hope Mills, NC 28348
(910) 491-9724 Fax to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: __Provider Services
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): SEE CHECKED BELOW:
_____Audit Information____
Specific information to be disclosed: ☒ Treatment Progress Summary ☒ Service Plan Documentation ☒ Verbal Communication
☒ Progress Note Doc. ☒ Alcohol/Drug Treatment Information ☒ Medical History and Physical ☒ Diagnosis/Psychiatric
☒ Discharge Summary ☒ Psychological Information ☐ Other
(List):____

I understand that this authorization will expire on the following date, event or condition: _____________1 Year_________________

REDISCLOSURE: Once information is disclosed pursuant to this signed authorization, I understand that the federal healthy 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 re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency disclosed mental health and developmental disabilities information protected by state law (NCGS 122C), substance abuse treatment information protected by federal law (42 CFR Part 2), or HIV/AIDS information protected by State Laws (G.S. 130A-143) we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION: I understand that with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in provider's Notice of Privacy Practices, a copy of which has been provided to me.

NOTICE OF VOLUNTARY AUTHORIZATION: I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that provider cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign unless this provision of health care is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

I further understand that I may request a copy of this signed authorization

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Signature of Client)	*(Date)*	*(Witness-If Required)*	*(Date)*
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(Signature of Parent/ Legal Guardian)	*(Date)*	*(Personal Representative/Authority)*	*(Date)*
NOTE: This Authorization was revoked on	------------------------	--	------------------------
	(Date)	*(Signature of Staff)*	*(Date)*

Clients Name___________________________ Record #____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name ____ Date of Birth_______________________________

Client Medical Record #______________________________ Client SS # (Optional) ______________________________

I ____ hereby authorize
(Client or Personal Representative)
I Do Care Counseling & Consulting Services, PLLC 3620 Legion Rd #210 Hope Mills, NC 28348
(910) 491-9724 **Fax** to disclose specific health information (Name of Provider/Plan)

from the records of the above named client to: Emergency Contact Information:
____
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): SEE CHECKED BELOW:
Specific information to be disclosed: ☐ Treatment Progress Summary ☐ Service Plan Documentation ☐ Verbal Communication ☐ Progress Note Doc. ☐ Alcohol/Drug Treatment Information ☐ Medical History and Physical ☐ Diagnosis/Psychiatric ☐ Discharge Summary ☐ Psychological Information ☒ Other (List): Emergency Situation: What, Who, Why, Where, When, How happened and Disposition of Emergency Situation.________________________________ ______

I understand that this authorization will expire on the following date, event or condition: ______________________________

REDISCLOSURE: Once information is disclosed pursuant to this signed authorization, I understand that the federal healthy 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 re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency disclosed mental health and developmental disabilities information protected by state law (NCGS 122C) substance abuse treatment information protected by federal law (42 CFR Part 2), or HIV/AIDS information protected by State Laws (G.S. 130A-143) we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

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I further understand that I may request a copy of this signed authorization

Signature of Client)	*(Date)*	*(Witness-If Required)*	*(Date)*
(Signature of Parent/ Legal Guardian)	*(Date)*	*(Personal Representative/Authority)*	*(Date)*
NOTE: This Authorization was revoked on	*(Date)*	*(Signature of Staff)*	*(Date)*

Clients Name___________________________ Record #____________

I DO CARE COUSNELING & CONSULTING SERVICES, PLLC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name ____ Date of Birth______________________________

Client Medical Record #____________________________ Client SS # (Optional) ______________________________

I ____ hereby authorize
(Client or Personal Representative)

I Do Care Counseling & Consulting Services, PLLC 3620 Legion Rd #210 Hope Mills, NC 28348
(910) 491-9724 ***Fax to disclose specific health information***
(Name of Provider/Plan)

from the records of the above named client to: Medical Provider
____
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): SEE CHECKED BELOW:
Specific information to be disclosed: ☒ Treatment Progress Summary ☐ Service Plan Documentation ☐ Verbal Communication
☒ Progress Note Doc. ☐ Alcohol/Drug Treatment Information ☒ Medical History and Physical ☒ Diagnosis/Psychiatric
☐ Discharge Summary ☐ Psychological Information ☒ Other (List):____medication list and lab results
____

I understand that this authorization will expire on the following date, event or condition: ______________________________________

REDISCLOSURE: Once information is disclosed pursuant to this signed authorization, I understand that the federal healthy 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 re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency disclosed mental health and developmental disabilities information protected by state law (NCGS 122C) , substance abuse treatment information protected by federal law (42 CFR Part 2), or HIV/AIDS information protected by State Laws (G.S. 130A-143) we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

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Signature of Client)	*(Date)*	*(Witness-If Required)*	*(Date)*
---	------------------------	---	-----------------------
(Signature of Parent/ Legal Guardian)	*(Date)*	*(Personal Representative/Authority)*	*(Date)*
NOTE: This Authorization was revoked on	------------------------	---	-----------------------
	(Date)	*(Signature of Staff)*	*(Date)*

Clients Name___________________________ Record #____________

I understand that I have a right to contact the agencies below at any time to discuss my complaint/grievance:

Disability Rights NC
www.disabilityrightsnc.org
2626 Glenwood Ave. Suite 550 Raleigh, NC 27608
877-235-4210 or 919-856-2195
Email: info@disabilityrightsnc.org

North Carolina Board of Licensed Professional Counselors
PO Box 77819
Greensboro, NC 27417
Phone 844-622-3575 Fax 336-217-9450
www.ncblpc.org

Please feel free to contact I Do Care Counseling & Consulting Service, PLLC Company representative for further clarifications of your rights.

Client's Signature: ______________________________ Date: ________________________
I Do Care Staff: _________________________________ Date:__________________________