Client Name: _____ DOB: _____ MID: _____ REC:_____

ARRAY OF BRIGHTER BEGINNINGS, INC..

813 A S. Oakland St.
Gastonia, North Carolina 28054
704-671-2694

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

******CONFIDENTIAL INFORMATION******

Medication will always be administered according to label instructions.
This form must still be returned to Array of Brighter Beginnings, Inc.. for the records

If consumer is **not on** prescription medication, **check here** ☐.

Parent/Legal Guardian signature: _____ **Date:** _____

☐ **No**, I do not want Array of Brighter Beginnings, Inc. service providers(s) to give the following prescription Medications to:_____ (Consumer Name).

Parent/Legal Guardian signature: _____ **Date:** _____

OR

☐ **Yes**, I give my permission for Array of Brighter Beginnings, Inc. service provider(s) to give the following prescription medications to:_____ (Consumer Name).

Parent/Legal Guardian signature: _____**Date:** _____

PHYSICIAN MUST COMPLETE THIS SECTION OR A COPY OF EACH PRESCRIPTION MAY BE ATTACHED

MEDICATION _____ RX # _____
DOSAGE AND TIME GIVEN: _____

MEDICATION _____ RX # _____
DOSAGE AND TIME GIVEN: _____

MEDICATION _____ RX # _____
DOSAGE AND TIME GIVEN: _____

_____ _____
Physician Signature **Date**

Client Name: _____ DOB: _____ MID: _____ REC:_____

813A S. Oakland Street
Gastonia, NC 28054
704215-6896

Consent and Agreement for Psychological Testing and Evaluation Services

I understand that the purpose of this evaluation is to provide information about ❑ me or ❑ _____ for this purpose:

❑ Treatment planning ❑ A civil or criminal case, or other legal proceedings

❑ Entry into a program ❑ Eligibility for services (specify): _____

❑ Other (specify): _____

I understand that a report of the findings of this assessment will be sent to Partners Behavioral Health Management.
This person or organization or designate will be responsible for disclosure or distribution of this report.

I, _____, agree to allow the psychologist named below to perform the following services:

❑ Psychological testing, assessment, or evaluation ❑ Report writing

❑ Consultation with ❑ School personnel ❑ Lawyers ❑ Other (specify): _____

❑ Deposition (that is, written or oral testimony given to a court, but not made in open court) ❑ Testimony in court ❑ Other (specify):

I understand that these services may include face-to-face interviewing or administering tests, questionnaires, checklists, and other assessment methods. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, constructing a report about the results and findings, and other activities to support these services. If I have questions or concerns about this assessment, the psychologist agrees to discuss these although some answers may be deferred until after completion of the testing and interview.

I also understand the psychologist agrees that the procedures for selecting, administering, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association, other professional organizations, and with the applicable state and federal laws.

I agree to cooperate and help as much as I can by supplying full and accurate answers and making a sincere effort. I understand that I may refuse to answer any question or terminate the evaluation whenever I wish. I understand that whatever I say during this evaluation may later be the subject of inquiry. I understand that the evaluator is required to notify authorities if the evaluator believes or suspects that a child is abused, or if the evaluator has reason to believe that I may harm others or myself.

_____ ___/___/___

Signature of client (or parent/guardian) Date

I, the psychologist, have discussed the issues above with the client (and/or his or her parent or guardian) and answered any questions raised. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____ ___/___/___

Signature of psychologist Date

❑ Copy accepted by client or ❑ Copy kept by psychologist

Client Name: _____ DOB: _____ MID: _____ REC:_____

Array of Brighter Beginnings and Partners Behavior
Health Authorization Consent

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (445 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. 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.

PURPOSE (Two- way consent)

☐ Ongoing communication
☐ Copy of record
☐ Legal or Insurance review
☐ Other _____
_____

RELEASE FROM: _____

Facility, agency or person listed above is authorized to release information

Agency Address: _____ **Agency Telephone Number** **Agency Fax Number**

Specific Information To Be Released

From: (MM/DD/YY) _____ To: (MM/DD/YY) _____

☐ All records & Details
☐ Other (Please specify) _____
Describe purpose of the requested use or disclosure

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immune deficiency virus (HIV).

Name of Consumer Whose Information if to be released:

Name: _____
First Middle Last

Address: _____ SSN#: _____
(Street/ PO Box, City ,State, Zip)

Date of Birth: _____ Phone number: _____
(MM/DD/YYYY) Home/ cell/ work (best number to reach)

RELEASE TO: The following individuals/ organizations may use the information released. A separate authorization must be completed if the information or purpose differs from individuals/organization listed below:

Name	***Address***	***Telephone/Fax#***	***Relationship***
Array of Brighter Beginnings Inc._____	813A S. Oakland Street Gastonia, NC 28054	704-215-6896/704-671-2694	_Provider____
_Partners Behavioral Health _____	_901 S. New Hope Road _____	_888-235-4673_____	__MCO_____

Patient's Rights , Revocation and Expiration

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. [If I want to revoke this authorization, I must do so in writing.] I may request to inspect or obtain a copy of the information used and disclosed per Array of Brighter Beginnings, Inc.'s Notice of Privacy Practices/Policy. I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Array of Brighter Beginnings, Inc. cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign. This **authorization will expire** when the requested health information noted in specific information section above is release to the recipient named in this document and the purpose of the release is satisfied.

SIGNATURES

Signature of consumer: _____ Date_____

Please print name: _____

Signature of legally responsible person or other personal representative
(If required):_____ Date_____

Please print name:_____Please explain representative's authority to act on behalf of consumer:_____

Client Name: _____ DOB: _____ MID: _____ REC:_____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (445 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

Consumer's Name	Social Security #	Medical Record ID	Date of Birth

I, the above named person, authorize

_____, to use or disclose to

Agency/person releasing information & Address (if needed)

Array of Brighter Beginnings, Inc. 813- A South Oakland St. Gastonia NC 28054

Agency or person to whom the requested use or disclosure will be made & Address (if needed)

The following protected information: historical, psychological, medical, social, vocational, educational, and behavioral data.

THIS DATA SHALL INCLUDE *(client must initial beside data to be used or disclosed)*

- ☐ Assessments
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Other Comprehensive Assessment
- ☐ Service Notes
- ☐ Service Plans/Goals
- ☐ Discharge Summary
- ☐ Financial/Reimbursement
- ☐ Substance Abuse/Treatment
- ☐ HIV/AIDS Information
- ☐ Social, Developmental,Medical History

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immune deficiency virus (HIV).

PURPOSE OF USE &DISCLOSURE

The purpose of the disclosure is _____

Describe each purpose of the requested use or disclosure

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. 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 discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. [If I want to 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 Array of Brighter Beginnings, Inc.'s Notice of Privacy Practices, a copy of which has been provided to me. If not revoked earlier, this authorization expires automatically upon _____

Date or event that relates to the consumer or the purpose of the use or disclosure

Or one year from the date it is signed, whichever is earlier.

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Array of Brighter Beginnings, Inc. cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign.

SIGNATURES

Signature of consumer_____ Date_____

Please print name_____

Signature of legally responsible person or other personal representative (if required):_____ Date_____

Please print name_____

Please explain representative's authority to act on behalf of consumer:_____

_____

Client Name: _____ DOB: _____ MID: _____ REC:_____

CONSENT FOR SERVICES

Array
OF BRIGHTER BEGINNINGS
Providing better tomorrows.

Consent for Services: I authorize Array of Brighter Beginnings, Inc. to provide care and treatment of services to me. This may include habilitative treatment, rehabilitative treatment, medication administration, transportation to/from medical appointments, psycho-education, mentoring, adaptive skill training, community integration, support counseling behavior management, crisis intervention, personal care, and emergency medical care, etc. I understand the consent may be withdrawn at anytime.

_____ _____
Consumer/Guardian Signature Date

_____ _____
Consumer/Guardian Printed Date

Client Name: _____ DOB: _____ MID: _____ REC:_____

EMERGENCY CARE CONSENT

Array OF BRIGHTER BEGINNINGS
Providing better tomorrows.

Emergency Care Consent: As a consumer or parent/legal guardian of a consumer, I give Array of Brighter Beginnings, Inc.. permission to obtain emergency care if the need arises. Array of Brighter Beginnings, Inc.. will make reasonable attempts to contact the consumer's parent/legal guardian or emergency contacts before obtaining emergency medical care unless life threatening.

Every effort will be made to honor the individual/parent/guardian choice of physician, hospital, and dentist. However, should an emergency arise that requires immediate assistance, the Array of Brighter Beginnings, Inc. employee will either call for emergency assistance through 911 or transport the consumer to the nearest emergency room or urgent care facility.

I understand the consent may be withdrawn at anytime.

_____ _____
Consumer/Guardian Printed Date

_____ _____
Consumer/Guardian Signature Date

Client Name: _____ DOB: _____ MID: _____ REC:_____

CONSENT FOR TRANPORTATION

I have read and understand the transportation rules listed below for Array of Brighter Beginnings, Inc.. I hereby voluntarily give consent for transportation by Array of Brighter Beginnings, Inc..

Transportation Guidelines/Rules:

- Consumer or legally responsible person must read and sign Consent for Transportation prior to receiving services.
- o No weapons, drugs, alcohol, or smoking, use of profanity, inappropriate touching anyone, leaving trash in the vehicle or throwing objects from the windows.
- Hands and objects are to stay inside, and windows and doors are to remain closed unless driver gives permission to open.
- Do not exit the vehicle until the driver gives permission.
- Seat belts are to be worn at all times
- The appropriate child restraint device/procedure will be used in accordance with North Carolina State law.

_____ _____

Consumer/Guardian Printed Date

_____ _____

Consumer/Guardian Signature Date

GRIEVANCE POLICY

I have received and understand Array of Brighter Beginnings, Inc.'s grievance policy. The policy states Array of Brighter Beginnings, Inc. will provide an effective channel for consumers to be heard and responded to regarding any services they deem inadequate or unsatisfactory.

_____ _____

Consumer/Guardian Printed Date

_____ _____

Consumer/Guardian Signature Date

Client Name: _____ DOB: _____ MID: _____ REC:_____

ACKNOWLEDGEMENT FORM
FOR RECEIPT AND REVIEW OF CLIENTS RIGHTS

I, the Guardian of _____have read or had explained to me information concerning client rights as presented in Array of Brighter Beginnings, Inc. Policy and Procedure Manual.

I further acknowledge that I have been presented a copy of the Client Handbook, which contains rules each client is expected to follow and possible penalties for their violation.

A. Information regarding the disclosure of confidential information.
B. How to obtain a copy of the client's treatment/habilitation plan,
C. Grievance procedure including the appropriate staff person to contact,
D. Information regarding policy for suspension/expulsion and discharge services,
E. Information regarding policy for search and seizure,
F. Fees and Collection Practices,
G. Right to contact the Governor's Advocacy Council for Persons with disabilities (GACPD).
H. Permitted restrictive interventions, protective devices will not be used.
I. The purpose, goals and reinforcement structure of any behavior management system used by Array of Brighter Beginnings, Inc.'s staff has been explained.
J. Information that the legally responsible person of a minor or incompetent client has been informed that he/she may request a notification after each use of a restrictive intervention and any request to be notified is documented (if restrictive intervention is permitted by Array of Brighter Beginnings, Inc.. 's staff)
K. I have been informed that a legally competent adult client may designate an individual to be notified after any use of a restrictive intervention or rights restriction, and that any for notification is documented.

Please check one of the following (for Residential Program Only)
☐ I request clothing/personal possessions in inventory assistance
☐ I do not request clothing/personal possessions in inventory assistance.

Consumer/Guardian Printed Date

DISCLOSURE OF CONFIDENTIALITY/PRIVACY NOTICE ACKNOWLEDGEMENT FORM

- Confidentiality (North Carolina General Status 122-C-52): Confidentiality applies to all facets of the individual's life. Array of Brighter Beginnings, Inc. will adhere to the consumer right that no confidential information acquired be disclosed by the agency. I acknowledge that Array of Brighter Beginnings, Inc.. has reviewed the disclosure of confidentiality with me.
- I acknowledge that I have been provided a copy of the Notice of Privacy Practices for Array of Brighter Beginnings, Inc. that addresses the Health Insurance Portability and Accountability Act of 1996.
- I understand that the Notice of Privacy Practices discusses how my personal health care information may be used and/or disclosed, my rights with respect to health care information, and how and where I may file a privacy-related complaint.
- I may review a copy of the Notice of Privacy Practices in the main office of Array of Brighter Beginnings, Inc.
- I may obtain a copy of this Notice of Privacy Practices from Array of Brighter Beginnings, Inc..
- I understand that the terms of this Notice of Privacy Practices may be changed in the future, and these changes will be posted in the main office of Array of Brighter Beginnings, Inc.. I may also request a copy of the new Notice of Privacy Practices by contacting the Executive Director and/or designee at 704-882-9553.

_____ _____

Consumer/Guardian Printed Date

_____ _____

Consumer/Guardian Signature Date

Client Name: _____ DOB: _____ MID: _____ REC:_____

CONSUMER RIGHTS LIMITATIONS/ RESTRICTIONS NOTIFICATION RIGHTS

_____I understand that as the legally responsible person of the minor consumer or incompetent adult mentioned above I will be notified of any rights that are limited or restricted. My name and address is as follows:

_____
_____
_____
_____

_____As a competent adult I understand that I may designate a person to be notified if my rights are limited or restricted.

_____I do request that _____be notified at this address:

(First and last name)

_____
_____
_____
_____

_____ _____

Consumer/Guardian Printed Date

_____ _____

Consumer/Guardian Signature Date

Statement of Provider Choice

I have received information regarding services which I am eligible to receive. I have been informed of providers from whom I am eligible to receive such services. Based on this information, I have made an informed choice of the services and providers.

I, Guardian of _____,
is selecting (name of Provider), Array of Brighter Beginnings, Inc. as my provider of choice for the following Services:

Name of Services _____

Name of Services_____

Name of Service: _____

Name of Service: _____

It has been explained that I may continue to receive services through my current provider or I may select another provider to deliver these same services.

Please note: It is the policy of Array of Brighter Beginnings, Inc. to uphold the integrity of the issue of choice for consumers.

Partners LME_
Area Program

MEDICAL AGREEMENT

I understand that with routine doctor/dental appointments it is the responsibility of the parent/legal guardian to provide transportation to appointments, to schedule those appointments, and to assume the financial responsibility for those appointments.

Medical Insurance Information

Name of participant_____ Effective Date: _____
Name of policy holder: _____

Primary Insurance Company: NC Medicaid

Address: _____

Phone: _____

Medicaid number _____ County:_____
Does the consumer have secondary medical insurance? ____☐__ Yes ___☐____No
If yes, will the secondary medical insurance cover any medical expense not covered by Medicaid? ____☐_Yes ____☐_No
Insurance Company Address Phone # Policy #
_____

_____

If No, Who will be responsible for any medical expense not covered by Medicaid?

Name: _____ Phone:_____

Address: _____

Client Name: _____ DOB: _____ MID: _____ REC:_____

Consent to Services

I as the consenting party/legal guardian (for minors) or for client receiving services agree/consent to services rendered by Mr. Jeffrey Lorence, M.A., Licensed Psychological Associate. I am aware that he is rendering psychological services ranging from specialized consultation to psychological evaluation and/or testing. I agree to pay for the services at the rate agreed upon by Mr. Lorence and myself. I or the contracting agency/referral source is responsible for payment of services agreed upon and agree to pay at the time services are rendered if there is no insurance company. I am aware that he will not release information contained in notes or reports unless they are released to me or other "service providers" at my request in written form. I am aware that Mr. Lorence follows ethical guidelines and HIPAA requirements regarding rendering services, release of information, storage of information, confidentiality and all other general regulations and requirements outlined by the State Psychology Board's regulations and statutes, HIPAA and adopted by the American Psychological Association. Mr. Lorence agrees to provide services and written reports in a timely manner and provide or send copies to me or another "service provider" at the address listed below. Parties listed below consent to release of written records/report.

Examiner/Psychologist:_____

Date:

Consenting party for minor client/or client_____

Date:

Name/Address where records are to be sent:

Array of Brighter Beginnings Inc. 813-A South Oakland St. Gastonia NC 28054