Attention! Attention! Attention!

If completing this New Consumer package from the Array of Brighter Beginnings, Inc. website follow these steps”

Step 1: Download Document First

Step 2: Complete all documents and sign

Step 3: Save to your computer

Step 4: Submit and email back to office or submit through website

Submit Documents Here

SUBMIT DOCUMENTS HERE

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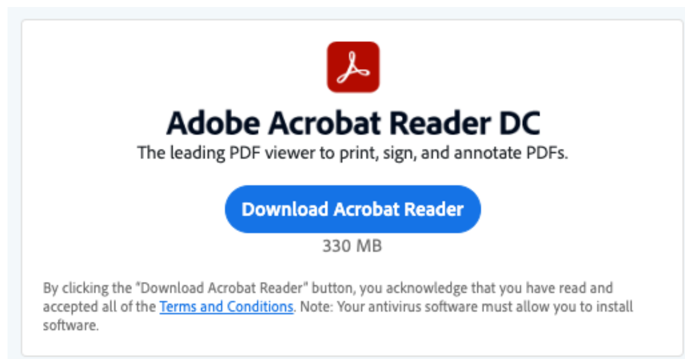

<<<<<<Click Here

Client Name: ____________________________ DOB: _____________ MID: ________________ REC:____________________

813A S.Ookland St.
Gastonia, NC 28054
704-671-2694

Application Date:_____________________

APPLICATION

CONFIDENTIAL INFORMATION

Consumer Name: ______________________________________ Nickname: ________________

D.O.B.: ____/____/______ Gender: ___________

Social Security # _____-____-________ Medicaid #_________________________

Street Address:____

City: _________________________ State: _________ Zip: __________ County: __________

Home # (   ) ______-________ Email address: _________________________

PARENT INFO:

Mother's Name_______________________	Father's Name___________________________
Daytime Phone # ____________________	Daytime Phone # _______________________
Emergency # ________________________	Emergency # ___________________________
Preferred # _________________________	Preferred # ____________________________
Street address: ______________________	Street Address: ________________________
City, State, Zip: _____________________	City, State, Zip:________________________

Consumer lives with? ________________________

Marital Status: married separated divorced other: ________________________________

If separated or divorced, who is custodian: ____

Are there visitation restrictions? ____

If Parent is NOT legal guardian:

Legal Guardian Name__________________________ Daytime Phone # ________________

Emergency # _______________ Preferred # ________________

Guardianship type: ________________

Legal Guardian Address:

____

Street City, State Zip Code

Emergency Contact Information

Contact's Name: ___________________________
Primary Phone # : ( ) _____-________
Secondary Phone #: ( ) _____- ________
Relationship: _______________________________

Preferred physician name for this consumer: _______________________________________

Address:

____

Street City, State Zip Code

Physician office # _______________ Office fax # ______________________

I give my permission for reciprocal communication between Array of Brighter Beginnings, Inc.. and the physician/contacts listed

_______________________________________ ___/___/_____

Signature of Parent/Guardian Date

DAY PLACEMENT or SCHOOL INFORMATION

Agency Name: __________________________________ Phone # __________________
Contact Name: __________________________________ Position: ___________________
Address:

____

Street City, State Zip Code

CONSUMER'S BEHAVIOR

Behaviors current or past?

PERSONAL

__ Biting
__ SIB-Self Abusive
__ Whining, Crying
__ Lying
__ Arguing
__ Temper Tantrums
__ Depressed
__ Hostile
__ Sexually Inappropriate
__Apathetic
__Physically Aggressive
__ Cursing
__ Assaultive Behavior (Hitting)
__ Aggressive (Property destruction)
__ Need for Behavior Intervention
__ Suicide Attempts/Threats
__ Alcohol Usage/Abuse
__ Lacks Guilt
__ Cruel to Animals
__ Spitting

HISTORY OF:

__ neglect
__ physical abuse
__ sexual abuse
__ emotional abuse

SOCIAL

__Leader
__Follower
__Outgoing
__Withdrawn
__Highly Nonverbal
__Poor Social Skills
__Manipulative
__Street Wise
__Shy

RESTIRICTIONS

__ From other gender
__ From same gender
__ From family contact with _______________
__ 1:1 constant supervision at all times

FAVORITE ACTIVITIES: (What does the consumer enjoy doing?)

____

____

FEARS/ DISLIKES: (Is the consumer afraid of anything, /anything that he/she really does not like?)

____

____

DAILY LIVING INFORMATION

(Please place a check in the area that applies)

	Independent	*Needs Assistance*	*Dependent*	*N/A*	*Addt. Comments:*
Dressing					
Bathing					
Ambulation					
Transfer					
Eating					
Drinking					
Toileting (urination)					
Toileting (defecation)					

Allergies: If yes, please list them

____

ANY Restrictions:

____

Special diet: ____

Favorite Foods: ____

Vision: normal __ normal with glasses/contacts __ impaired __ blind __

Hearing: normal __ normal with glasses/contacts __ impaired __ deaf __

Communication: normal __ gestures __ sign language __ augmentative device __

Seizures: active __ med controlled __ history but not active __ absent __

tonic-clonic __ atonic __ myoclonic __ simple partial __ complex partial ___

(history) hourly __ daily __ weekly __ situational __ but controlled with meds ___

Diabetes: diet controlled __ insulin controlled __ other _________________________

Blood Pressure: High pressure __ Low pressure __

Anemia: yes __ no __ history __

Bulimia: yes __ no __ history __

Migraines: yes __ no __ history __

Tuberculosis: yes __ no __ history __

Anorexia: yes __ no __ history __

Asthma: yes __ no __ situational ___________________

ARRAY OF BRIGHTER BEGINNINGS, INC..

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

AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION

****CONFIDENTIAL INFORMATION****

Medication will always be administered according to label instructions.

___**No**, I do not want Array of Brighter Beginnings, Inc. service provider(s) to give non-prescription medication(s) to ____ (consumer name).

Signature Parent/Guardian ____ **Date** _______________

OR

___**Yes**, I give my permission for Array of Brighter Beginnings, Inc. service provider(s) to give the following non-prescription medication or the appropriate generic substitute to ____ (consumer name).

Signature Parent/Guardian ____ **Date** _______________

Non-Prescription Medication Approved to give: ____
Purpose: (headache, toothache, fever, etc.) ____

Non-Prescription Medication Approved to give: ____
Purpose: (headache, toothache, fever, etc.) ____

Non-Prescription Medication Approved to give: ____
Purpose: (headache, toothache, fever, etc.) ____

____ _________________________
Signature Parent/Guardian **Date**

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:____________________

Health Information Form

A. Identification

Client's name: ____ Date: ___ ___ ___

B. Medical caregivers

List at the top your current doctor or primary care provider (PCP) or medical agency. Then list other health care providers, agencies, or clinics treating you in the last 5 years.

Name	Specialty	Address	Phone#	Date of last visit

C. Medical history

1. Starting with your childhood and proceeding to the present, list *all* illnesses, accidents/injuries, surgeries, hospitalizations (including ones for mental illness or substance abuse), periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness, injury, or other condition	Treatment received	Treated by	Results

(continued)

Age	Illness, injury, or other condition	Treatment received	Treated by	Results

2. Are you allergic to medications or anything else? ☐ No ☐ Yes. If yes, please describe here.

To what?	Reaction you have	Allergy medications you take

3. List a// medications, drugs, or other substances you take or have taken in the last year-prescribed medications, over-the-counter vitamins, supplements, herbs, and others.

Medication, drug, or other substance	Dosage and how often	For what condition?	When started	Effects	Prescribed and supervised by:

4. Have you ever been exposed to toxic chemicals? ☐ No ☐ Yes. If yes, please describe here.

Dates	Kind of work or location	Kinds of chemicals	Effects

D. Health habits

1. How much physical exercise do you get? I (do)_____________________________, for______________(length of time), _ days per week.

(continued)

2. Do any of the following describe you? ☐ Very conscious of eating healthily ☐ Tend to overeat (binge) ☐ Eat a balanced diet most of the time ☐Watch my weight very closely ☐ Eat junk foods ☐ Other:____
3. How was your appetite in the last month? ☐ Normal ☐ Very good ☐ Low

   Do you try to control your eating in any way? ☐ No ☐ Yes. If yes, how (special diets, medications)?

   ____

   Why? ____
4. I have ☐ gained ☐ lost __ pounds within the last 6 months.
5. What hobbies do you enjoy? ________________________________ How often?_______________
6. What problems do you have with sleep?____

   What do you do to help you sleep?____
7. Have you ever injected drugs? ☐Yes ☐ No ☐Talk about later

   Ever shared needles? ☐Yes ☐ No ☐Talk about later
8. Have you had HIV testing in the last 6 months? ☐ No ☐ Yes ☐Talk about later

E. For women only

1. Menstruation: At what age did you start to menstruate (get your first period)? __ years old.

   How regular are your periods?___________ How long do they last? ______________________

   How much pain do you have?___________ How heavy are your periods?____________________

   Other experiences during periods? ____
2. Please list all of your pregnancies and attempts to get pregnant:

Your age?	**What happened with this pregnancy? Miscarriage, abortion, stillbirth, child born, etc. Other problems?**

3. At what age did you first notice signs of menopause?____ _

   If you are in or around the age of menopause: What signs or symptoms do you have now (hot flashes, mood swings, menstrual period changes, body pain, etc.)? ______________________________________

   ____

   At what age did menstruation stop?____ _

F. Other

Are there any other medical or physical problems that you are concerned about, or that you think I should know about? ☐ No ☐Yes. If yes, describe: ____

____

Array OF BRIGHTER BEGINNINGS
Providing better tomorrows.

Referral Form for Mental Health Services

Client Information

Name:	Date of Birth:	Race/Ethnicity:
Gender: ❒ Male ❒ Female ❒ Couple	School & Grade:	
Services Requested: ❒ Office-Based Outpatient	❒ School Based (if therapist is available)	
CONTACT NUMBERS:	Message ok? ❒ Yes ❒ No	
ADDRESS:		

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	Type of setting: ❒ Home ❒ Group Home ❒ Foster Home ❒ Psychiatric hospital ❒ Other

Payment Information:

Type of Insurance ❒ Medicaid (county) ❒ HealthChoice ❒ BCBS ❒ Other If no insurance, household income:		
Insurance ID#	Group#	Phone #

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name	Mailing Address
Phone#	Email address
How did you hear about Array of Brighter Beginnings?	

Child/Adult Mental Health Information:

Current medication & dosage	Current DSM-IV Diagnosis
1.	Axis I:
2.	Axis II:
3.	Axis III:
4.	Axis IV:
5.	Axis V:

Prescribing Physician name & Phone :					
Current Mental Health Symptoms:	**Unknown**	**Not Present**	**Mild**	**Moderate**	**Severe**
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

____

____

____

____

Additional Comments ____

____

Has patient received counseling in the past?: ______________________________________

Availability:____

Additional Comments:

Client Name: ___________________ DOB: _____________ MID: ________________ REC:____________________

Array OF BRIGHTER BEGINNINGS

Providing better tomorrows.

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 _____________________________________.
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:____________________

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	____Service Notes	____Substance Abuse/Treatment
Psychiatric Evaluations	____Service Plans/Goals	____HIV/AIDS Information
Psychological Evaluations	___ Discharge Summary	___ Social, Developmental,Medical History
Other Comprehensive Assessment	____Financial/Reimbursement	

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

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

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

update 2 2-9-2021

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 Sign   Date

update 2 2-9-2021

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

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