SUNRISE CLINICAL ASSOCIATES, PLLC
3500 Westgate Drive, Suite 604, Durham, NC 27707-2534 • Office: (919) 493-5013 • Fax: (919) 493-5026

Cardinal Innovations Intake Checklist for Child/Adolescent Clients

Consumer's Name: ______________________________ Date of Intake: ______________

- ☐ Child/Adolescent Intake Form
- ☐ Client Financial Agreement
- ☐ Emergency Medical Care Consent
- ☐ Client Acknowledgement 24 Hour On-Call Service
- ☐ Notice of Client Rights & Privacy Practices
- ☐ Acknowledgement Form How to Obtain Access to Service Record
- ☐ Client's Rights
- ☐ Client's Responsibilities
- ☐ Rights to Confidentiality
- ☐ Confidentiality
- ☐ Statement of Provider Choice
- ☐ Client Orientation
- ☐ Additional Consents/Acknowledgements
- ☐ Consent for Treatment (Intensive In-Home)
- ☐ Consent for Treatment (Outpatient Therapy)
- ☐ Consent to Audio Recording and Transcription
- ☐ Consent for Treatment (DA or CCA)
- ☐ Consent for Psychiatric Evaluation and Medications Management
- ☐ Participation in Treatment (Intensive In-Home)
- ☐ Consent for Psychological Testing and Evaluation
- ☐ Acknowledgement whether Receiving Additional Services from another Provider Agency
- ☐ NCTOPPS
- ☐ Coordination of Care Standardized Letter
- ☐ Authorization to Disclose Health Information forms (2) (Revised 1-3-18); **Examples:** Primary Care Physician or Clinic / Dentist, School (teachers, guidance counselors, athletic coach, principal), DSS (Social Worker), Dept. of Juvenile Justice, Relatives/Emergency Contacts (grandparents, aunts, uncles).

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CHILD/ADOLESCENT INTAKE FORM

Intake Date: ________________________________

Medical Record Number: ____________________

Client Name (First, Last, Middle Initial): ____

Parent or Guardian Name (First, Last, Middle Initial):_______________________________________

Sex: ___M ___F Age: _____ DOB: __________ Social Security Number: _______________

What's your preferred gender? _______________________

What's your gender identity? _________________________

Race/Ethnicity (Circle One): Asian Caucasian/W Other, please specify______________

Address: _________________________________ City: _________________________________

_________________________________ State: ________________________________

Zip Code: _________________________________ Religious Affiliation: ___________________

Email:

Home Phone: ________________________ Work Phone: _______________________

Grade Last Attended

School Name: ___________________________ City:

Phone Number: ___________________________ State:

....

Emergency Contact Information

Name (First, Last, Middle Initial): ____

Address: __________________________ Relationship to Client: ______________________

__________________________ City: _______________________________________

Zip Code: _________________________ State: ______________________________________

Email: ____________________________ Home Phone: ______________________________

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CHILD/ADOLESCENT INTAKE FORM

Medical History

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

Drink? Yes No If Yes, How Much? ______________________________

Use Illicit Drugs? Yes No

If Yes, How Much and what type? ___________________________________

Please List All Prescriptions and Dosages:

____
____
____
____
____

Please List Any Allergies:

____
____
____
____

Please List Any Current Medical Conditions:

____
____
____
____

Are you currently under a doctor's care? Yes No If Yes, Why? _________________________

Primary Care Doctor: _________________________ Phone Number: ____________________

City: __________________________ State: ____________________________

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

If Yes, When, Where and Why?

____
____

Have you ever been Hospitalized for a Mental Illness? Yes No

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CHILD/ADOLESCENT INTAKE FORM

If Yes, When, Where and Why?

____

____

Have you Ever Been Treated by a Mental Health Professional? Yes No

If Yes, When, Where, and Why?

____

____

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

If Yes, When, Where and Why?

____

____

………

Insurance Information

Insurance Provider: ____________________ **Policy Number:** ______________________________

Group Number: ______________________

Policy Holder's Name (First, Last, Middle Initial): ____

Address: ______________________________ **Relationship to Client:** ______________________

______________________________ **City:** ____

Zip Code: ______________________________ **State:** _______________________________________

Email: _________________________________ **Home Phone:** ______________________________

………

To Be Completed By Office Staff

Intake Completed By: __________________ **Reviewed By:** ___________________________

Location of Intake (circle one): Office Client's Home Other: ______________________________

Assigned Qualified Professional: ____

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CLIENT FINANCIAL AGREEMENT

Sunrise Clinical Associates, PLLC will accept the following insurance for services rendered:

Medicaid OR Health Choice

Client Name:		MR#:	
Address:		County:	
City:		Zip:	
Phone:		SS#:	
Policy #:		DOB:	

I have the following insurance (please attach a copy of insurance card):

☐ **Medicaid**

☐ **Health Choice**

☐ I understand that because I receive Medicaid, my minimum payment is zero for all Medicaid covered services.

☐ I understand that because I receive Health Choice, my minimum payment is zero for the Health Choice covered services.

☐ I agree to notify Sunrise Clinical Associates, PLLC immediately when there is a change in my insurance coverage or county of residence.

☐ I understand that if there is a termination of my insurance for any reason, Sunrise Clinical Associates, PLLC will be unable to continue rendering services.

Client/Legally Responsible Person:________________________________ **Date:** _______________

Staff Signature: ____ **Date:** ________________

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Emergency Medical Care Consent

In the event of an emergency, I authorize Sunrise Clinical Associates, PLLC (SCA, PLLC) to seek emergency care from hospital or physician listed below.

I understand that SCA, PLLC will try to reach the legally responsible person and/or individuals listed on the Emergency Contact List as quickly as possible in an emergency situation. I agree to hold SCA, PLLC harmless from any liability that results from the provision of transportation or medical coordination.

Emergency Contact Name(s): Phone #s:

___________________________________ ____________________________

___________________________________ ____________________________

Client Physician's Name: Phone #:

_________________________________ _____________________________

Insurance Information: Hospital Preference:

___________________________________ ____________________________

Medical Conditions:

____

____

Allergies: ____

Medications: ____

If the above physician cannot be reached, a licensed physician can be called or the above named client may be taken to the nearest hospital emergency room if hospital preference is not the closest. I understand that this consent is valid for one year and may be revoked in writing at any time.

____

Client/Legally Responsible Person Date

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CLIENT ACKNOWLEDGEMENT

24 Hour On-Call Service

I, ____ have been informed that:

Sunrise Clinical Associates, PLLC provides a 24 hour, 7 days a week emergency telephone number (919) 698-9094 when a client is in a crisis situation. The individual answering this phone number will be qualified to provide crisis intervention, including face-to-face services. Furthermore, I have been given this number and encouraged to post it along with my crisis plan for emergency accessibility when needed.

____
Client or Legally Responsible Person Signature Date

____
Witness Signature Date

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REMOVE FROM INTAKE PACKET AND GIVE TO CLIENT TO KEEP

CLIENT ACKNOWLEDGEMENT (24 Hour On-Call Service)

LITERATURE READ AND GIVEN TO CLIENTS

Sunrise Clinical Associates, PLLC is responsible for providing 24/7/365 on-call First Responder services to all recipients receiving enhanced services (which includes Community Support Team and Intensive In-Home services) in a professional and responsive manner. First responder services are provided by Qualified Professionals. Upon initiation of your person-centered plan, a crisis plan will also be developed to include specific proactive and reactive interventions to prevent harm, hurt and danger to you or others when you can't control a negative situation.

A crisis plan is a set of written instructions you want followed if you are experiencing a behavioral health emergency. Writing a crisis plan requires you to think about what the early signs of trouble are for you. Therefore, whenever you feel there are safety risks to you or others, immediately call our crisis phone after business hours or on weekends.

(919) 698-9094

As the First Responder, we want to prevent unnecessary hospitalization and arrests. When you call the crisis phone and no one answers, please leave a detailed description of your crisis on voice mail and identify who you are. A Sunrise Clinical professional will respond within 15 minutes of your initial call. If deemed necessary, we will provide a face-to-face assessment within two (2) hours of a crisis. Professional staff will use sound clinical judgment to address specific crises.

If you understand this handout, please sign the attached "Client acknowledgement 24 Hour On-Call Service" Form.

Sunrise Clinical Associates, PLLC

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NOTICE OF CLIENT RIGHTS & PRIVACY PRACTICES

Consumer Name: ___________________________________ MR #:______________

Date of Birth: ____________________ Medicaid #: __________________

I, ____ acknowledge that I have received a written summary of the Privacy Practices and Client Rights by Sunrise Clinical Associates, PLLC

___________________________________	__________________
Client/Legally Responsible Person	**Date**
___________________________________	__________________
Witness Signature	**Date**

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NOTICE OF PRIVACY PRACTICES (REMOVE & GIVE TO CLIENT!!!)

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to all of the services operated by Sunrise Clinical Associates, PLLC

Our Pledge and Legal Duty to Protect Health Information about You

The privacy of your health information is important to us. We are required by federal and state laws to protect the privacy of your health information. We must give you notice of our legal duties and privacy practices concerning your health information.

- We must protect information that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect your health information.
- We must explain how, when and why we use or disclose your health information.
- We may only use of disclose your health information as we have describe in this Notice.
- We must abide by the terms of the Notice currently in effect.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all health information that we maintain. We will post a revised Notice in our offices and make copies available to you upon request.

Our Uses and Disclosures of Your Health Information

Sunrise Clinical Associates, PLLC is permitted to make uses and disclosures of protected health information for treatment, payment, health care operations, data for oversight and evaluation, as described in the following examples:

a. **Treatment** – For example we may disclose information to a consulting psychiatrist in order to develop a plan of medical treatment. As necessary, we may share information within Sunrise Clinical Associates, PLLC for treatment payment and health care operations.

b. **Payment** – For example we may be required to disclose information about treatment to the insurance company or medical assistance in order to receive authorization for payment.

c. **Health care operations** – An employee of Sunrise Clinical Associates, PLLC may have access to information about you when evaluating treatment effectiveness as part of a quality assurance project.

d. **Data for Oversight and Evaluation** - Data collected from North Carolina – Treatment Outcomes and Program Performance System (NC TOPPS) This program measures the quality of services by capturing key information on a consumer's service needs and life situation during a current episode of care. Overall, it is for the purpose of oversight and evaluation of the quality and effectiveness of services. This data can be shared with other provider agencies, LME/MCO or primary medical care providers for the purpose of coordinating care for a specific individual.

e. **Business Associates** – Sunrise Clinical Associates, PLLC may disclose information about you to third party "business associates" that perform various activities for Sunrise Clinical Associates, PLLC. Whenever this occurs Sunrise Clinical Associates, PLLC will have a written agreement that the business associates protect the privacy of your health information.

f. **Appointment Reminders/Information** – Sunrise Clinical Associates, PLLC may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you or your child/family.

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NOTICE OF PRIVACY PRACTICES (REMOVE & GIVE TO CLIENT!!!)

Uses and Disclosures Authorized by Law

Sunrise Clinical Associates, PLLC is permitted or required, under specific circumstances, to use or disclose protected health information without your written authorization. These circumstances include:

1. Sunrise Clinical Associates, PLLC shall disclose client information without written consent under the following circumstances:
   - **When mandated by federal or state law**, including the mandatory reporting requirements under the maltreatment of minors and vulnerable adult laws;
   - **When the client communicates to Sunrise Clinical Associates, PLLC a specific serious threat of physical violence against a clearly identified potential victim or against the client's self or against society in general,** Sunrise Clinical Associates, PLLC may release only the information that is necessary to avoid the infliction of physical violence. Sunrise Clinical Associates, PLLC shall release this information to law enforcement or other appropriate authorities and to the potential victim or victim's legal representative;
   - An organization may disclose information to law enforcement **officials if a client is a victim of a crime or perpetrates a crime against Sunrise Clinical Associates, PLLC;**
   - Sunrise Clinical Associates, PLLC must disclose information to law enforcement officials **if a client is currently involved in an emergency interaction with the law enforcement agency and the disclosure is necessary to protect the health or safety o the patient of another person;**
   - If Sunrise Clinical Associates, PLLC has reason to believe that **a pregnant client has used a controlled substance during pregnancy.**

2. **For a health oversight activity** such as an audit, criminal investigation, investigation by a professional licensing board (i.e. Board of Psychology or Board of Social Work) or investigation by the U.S. Department of Health & Human Services.

3. **For judicial or administrative proceedings,** such as responding to a county, state or federal court order, legal order, subpoena or other legal documents.

4. **To Military Authorities/National Security.** We may give health information to authorized people from the U.S. military, foreign military, and U.S. national security or protective services.

5. **To Correctional Facilities.** We may give the health information of an inmate or other person in custody to law enforcement or a correctional institution.

6. **Medical Emergency.** We may use or give your health information to help you in a medical emergency.

7. **Public Health Risks.** We may give health information about you for public health purposes that include the following:
   - Reporting and controlling disease (such as tuberculosis), injury or disability;
   - Notifying a person who may have been exposed to a disease or be at risk for catching or spreading a disease or condition.

8. **§ 122C-53. Exceptions; client.**
   (b) A facility may disclose the fact of admission or discharge of a client to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.

9. **§ 122C-54. Exceptions; abuse reports and court proceedings.**
   (c) Certified copies of written results of examinations by physicians and records in the

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NOTICE OF PRIVACY PRACTICES (REMOVE & GIVE TO CLIENT!!!)

cases of clients voluntarily admitted or involuntarily committed and facing district court hearings and re-hearings pursuant to Article 5 of this Chapter shall be furnished by the facility to the client's counsel, the attorney representing the State's interest, and the court. The confidentiality of client information shall be preserved in all matters except those pertaining to the necessity for admission or continued stay in the facility or commitment under review. The relevance of confidential information for which disclosure is sought in a particular case shall be determined by the court with jurisdiction over the matter.

10. (f) A State facility and the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may disclose confidential information to staff attorneys of the Attorney General's office whenever the information is necessary to the performance of the statutory responsibilities of the Attorney General's office or to its performance when acting as attorney for a State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill.

11. **§ 122C-55. Exceptions; care and treatment.**
(a3) Whenever there is reason to believe that a client is eligible for benefits through a Department program, any State or area facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with an area facility or State facility or the psychiatric services of the University of North Carolina Hospitals at Chapel Hill. Disclosure is limited to that information necessary to establish initial eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services provided to the client.

12. (a4) An area authority or county program may share confidential information regarding any client with any area facility, and any area facility may share confidential information regarding any client of that facility with the area authority or county program, when the area authority or county program determines the disclosure is necessary to develop, manage, monitor, or evaluate the area authority's or county program's network of qualified providers as provided in G.S. 122C-115.2(b)(1)b., G.S. 122C-141(a),

13. (g2) Whenever there is reason to believe that the client is eligible for educational services through a governmental agency, a facility shall disclose client identifying information to the Department of Public Instruction. Disclosure is limited to that information necessary to establish, coordinate, or maintain educational services. The Department of Public Instruction may further disclose client identifying information to a local school administrative unit as necessary.

14. (k) Notwithstanding the provisions of G.S. 122C-53(b) or G.S. 122C-206, upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client or his legally responsible person, the responsible professional shall provide the next of kin, or family member, or the designee, notification of the client's admission to the facility, transfer to another facility, decision to leave the facility against medical advice, discharge from the facility, and referrals and appointment information for treatment after discharge, after notification to the client that this information has been requested.

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NOTICE OF PRIVACY PRACTICES (REMOVE & GIVE TO CLIENT!!!)

Other uses and disclosure will be made only with your written authorization, and you may revoke such authorization at any time through a written notice to Sunrise Clinical Associates, PLLC who is providing services to your child (ren).

Your Individual Rights Regarding Your Protected Health Information

Access – You have the right to access and receive a copy or a summary of your health information contained in clinical, billing and other records that we maintain and use to make decisions about you. You may request that we provide copies in a format other than photocopies. We will use the format your request unless we cannot practicably do so. You must make this request in writing to obtain access to your health information. You may obtain a form to request access from your care provider. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. There might be limited situations in which we may deny your request. Under these situations, we will respond to you in writing, stating why we cannot grant your request and describing your rights to request a review of our denial.

Amendment - You have the right to amend your protected health information, as provided by federal or state regulation. Requests to amend your protected health information must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Accounting of Disclosures – You have the right to request a listing of certain disclosures we have made of your health information. Requests for an accounting of disclosures must be in writing and address to the Corporate Compliance Officer. You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). We will provide you one accounting in any 12-month period free of charge.

Restriction – You have the right to request that we place additional restrictions on our use or disclosure of your health information. Sunrise Clinical Associates, PLLC is not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Confidentiality Communication – You have the right to request that we communicate with you in a specific way or at a specific location about your health information. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Copy of this Notice – You have the right to obtain a paper copy of this Notice from Sunrise Clinical Associates, PLLC upon request. You also have the right to request to receive the Notice electronically, and still retain the right to receive paper copy.

QUESTIONS AND COMPLAINTS

Individuals may bring their questions or concerns to Sunrise Clinical Associates, PLLC, if they believe their privacy rights have been violated. Sunrise Clinical Associates, PLLC contact person for matters relating to these issues is:

Anya Odim
3500 Westgate Drive, Suite 604
Durham, NC 27707-2567
Phone: (919) 493-5013

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In addition you have the right to submit a written complaint to the U.S. Department of Health and Human Services (Attention: Office for Civil Rights). We support your right to the privacy of your health information.

You will not be penalized for filing a complaint.

I have received a copy of Notice of Privacy Practices, which describes this agency's methods for protecting the privacy of my health information that is used in providing healthcare services to me.

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ACKNOWLEDGEMENT FORM

HOW TO OBTAIN ACCESS TO SERVICE RECORD

You may obtain a "Patient's Access to Clinical Record Information" form. Upon receiving your request, we will process it within 7-14 business days. If we deny your request, we will explain ourselves in writing. You may appeal our denial to the Chief Executive Officer (CEO) of Sunrise Clinical Associates, PLLC. If you believe that your information is wrong or some information is missing in your record, you must request, in writing, that we correct or add to the record by writing a letter to the QA/QI Director (Compliance Officer). We will respond within 30 days of receiving your request. We may deny the request if we determine that the information is: (1) correct & complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed. Any denial will state the reason for denial and explain your rights to have the request and denial, along with any statement in response that you provide, added to your service record. If we approve the request for amendment, we will change the information in your record, inform you, and tell others who need to know about the change.

Sunrise Clinical Associates, PLLC also has an approved policy and procedures in place that addresses how to obtain documentation from your service record.

I clearly understand the above and have been explained the proper procedures of how to have the right to have access and review service record.

____________________________ ___________

Consumer or Legally Responsible Person Date

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Client's Rights

As a client at Sunrise Clinical Associates, PLLC (SCA, PLLC) you are entitled to certain rights, which include the below: This form should be completed at admission, upon request, and annually thereafter.

- The right to be treated with dignity, privacy, humane care and freedom from mental and physical abuse, neglect and exploitation;
- The right to have freedom from financial or other exploitation, retaliation and humiliation;
- The right to live as normally as possible while receiving care and treatment;
- The right to receive age-appropriate treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability services. Services cannot be denied , interrupted or reduced without good cause;
- The right to an individualized written Person Centered Plan setting forth a program to maximize the development or restoration of capabilities;
- The right to be informed of the procedure for obtaining a copy of their treatment/PCP plan
- The right to have access or referral to legal entities for appropriate representation;
- The right to confidentiality as governed by the General Statutes, North Carolina Administrative Codes and HIPAA;
- The right to communicate and consult with his/her legal responsible person;
- The right to be informed consent or refusal or expression of choice regarding: (1) service delivery, (2) release of information, (3) concurrent services and (4) composition of the delivery team;
- The right to be free from abuse, corporal punishment, and involuntary seclusion. A person must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving this resident, family members or legal guardians, friends, or other individuals;
- The right to participate in the development of the Person Centered Plan to receive services offered by SCA, PLLC and to be informed the expectations of all participants involved in the implementation of the Person Centered Plan;
- The right to help develop discharge and after care plans;
- The right to have access to his/her records, which include medical and mental health information;
- The right to education;
- The right to the least restrictive or least intrusive treatment alternative available and appropriate to the client’s care;
- The right to not be subjected to sexual advances, sexual harassment, or sexual offenses of any nature;
- The right not to participate in public performances/appearances (on behalf of the agency) against she/he wishes;

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- The right to have identity protected in the context of agency reports;
- The right to accept or refuse services: By law, you can accept or refuse any service, medication, test or treatment. However, during an emergency situation, treatment may be necessary without your permission.
- The right to exercise the same civil rights and remedies as any other citizen, e.g., own and dispose of property, make purchases, enter into contractual relationships, register and vote, bring civil actions, and marry and get a divorce, unless the exercise of a civil right has been precluded by an un-revoked adjudication of incompetence;
- The right to receive a timely response from SCA, PLLC for service request;
- The right to be fully informed of the services that will be provided, the alleged benefits, potential risks, and possible alternatives;
- The right to receive quality services and supports from Sunrise Clinical Associates, PLLC;
- The right to request a change in service provider without the fear of reprisal or discrimination;
- The right to maintain communication privileges at all reasonable times;
- The right to be informed within a reasonable time of any anticipated ending of service;
- The right to participate in any decision to change agencies or chose other arrangements should services be ended;
- The right to participate in appropriate and generally acceptable social interactions and activities with other individuals and members of the community;
- The right to make own choices;
- The right to a grievance procedure that includes the right to express dissatisfaction with services rendered;
- The right to have access to self-help and advocacy support services;
- The right to investigate and resolve alleged infringement of rights;
- The right to be informed of all of your rights within the first three visits to your community provider;
- The right to ask that printed information explaining your rights be given to you in a way that you can understand;
- The right to know what to do and whom to call if you believe someone is trying to take away your rights;
- The right to be informed any rules you need to follow. This information should be shared with you when you begin receiving services;
- The right to be treated politely, attentive and responsive to your needs and values;
- The right to have the chance to know the most likely results of your decision and what other choices you have;
- The right to know about medication: You have the right to know the possible side effects of medication and to be free from unnecessary or excessive medication. Medication cannot be used as a punishment, discipline or for the convenience of staff;
- The right to receive medical treatment if you are in need medical care;
- The right to appeal any changes to the services you already receive or any services you and SCA, PLLC have requested to receive; and
- The right to receive special accommodations.

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Client Rights will be explained and distributed to the client prior to the initiation of agency services and annually. This explanation will be in a language person served can reasonably understand.

Client or Legally Responsible Person has the right to contact Disability Rights of North Carolina at 1-877-235-4210, the Division of Health Services Regulation at 1-800-624-3004, Care-Line at 1-800-662-7030 and North Carolina Mental Health Consumer's Organization at 1-800-326-3842 or the responsible Managed Care Organization (MCO) if they feel their rights have been violated.

I understand the above rights upon receiving care from Sunrise Clinical Associates, PLLC

____ ____________________
Client or Legally Responsible Person Date

____ ____________________
Staff Member Signature Date

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Client's Responsibilities

As a client at Sunrise Clinical Associates, PLLC (SCA, PLLC) I have certain responsibilities which include:

- I will follow the rules of the program at SCA, PLLC.
- I will be on time for all appointments and call if I can't make an appointment.
- I will be available for meetings in the home, community or at the agency.
- I will allow agency to make home visits as appropriate.
- I will meet with physicians or other treatment providers as scheduled.
- I will present my insurance card when requested by SCA, PLLC.
- I will participate in developing and reviewing the Person Centered Planning and provide signature on required documents.
- I will talk to my assigned Qualified Professional and others on my planning team often about my needs, preferences and goals and how I think I am doing at meeting my goals.
- I will inform SCA, PLLC when I am experiencing problems.
- I will call the agency if moving (change of address), hospitalized (for any reason) or leaving the local area for an extended period of time.
- I will let SCA, PLLC know about changes in my name, insurance, address, telephone number or my finances.
- I will actively be involved in the assessment, transition and discharge planning.
- I will let SCA, PLLC know if I decide to discontinue services.
- I will inform the agency of any changes in funding or insurance coverage.
- I will take responsibility for my own health.
- I will treat staff and other consumers with respect and consideration.

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- I will not verbally, physically abuse or harass any client or staff at SCA, PLLC. If this is not followed, my services might be reduced, restricted or terminated.
- I will respect the confidentiality and privacy of other consumers.
- I will notify SCA, PLLC about any changes in my symptoms, medications or physical conditions that could affect my mental health.
- I will not steal from the agency, its staff or other clients.
- I will be responsible for my personal property.
- I will not sell, distribute, conspire, or obtain any illegal substances while on SCA, PLLC property.
- I will take my medication as prescribe.
- I will not disclose or discuss any information disclosed in my group participation (if applicable) by any client or staff as SCA, PLLC.
- I will maintain respectful communication (verbal and non-verbal) and gestures with any client or SCA, PLLC.
- I am responsible for following the recommended Person Centered Plan for treatment and services. It is my responsibility to inform a team member if I do not understand the Person Centered Plan, if I will be unable to follow through with it, or if I desire changes to my Person Centered Plan.

I understand the above responsibilities upon receiving care from Sunrise Clinical Associates, PLLC

Client or Legally Responsible Person Signature/Date:____

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Rights to Confidentiality

(Protected Health Information)

Use/disclosure of confidential consumer information shall not be permitted except as authorized under North Carolina General Statue 122C-52 through 122C-56 and NCGS 130A-143 and in accordance with NC MH/DD/SA Confidentiality Rules and HIPAA; or in the event of confidential information relating to consumers for substance abuse services, in accordance with Federal Rules 42 CFR, Part 2, unless the State Statues and rules are more restrictive.

I, ______________________________, understand that Sunrise Clinical Associates, PLLC (SCA) must comply with all local, state, and federal privacy policies relating to my protected health information. I affirm that I have received a paper copy of SCA's policies and have been given an opportunity to have them explained in language I understand. I affirm I accept the conditions of the Protected Health Information (PHI) policy.

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CONFIDENTIALITY

Confidentiality Requirements and Exceptions to Confidentiality

1. Confidential information may not be released without written consent except in emergency or as provided for in General Statutes 122C 152 through General Statutes 122C 156.

   Consent for Release - Employees may not release any confidential information until consent for release form has been obtained.

   Notice to Consumer - Sunrise Clinical Associates, PLLC maintains confidential information on the consumer and this document serves as a written notice to the consumer or legally responsible person at the time of admission that disclosure may be made of pertinent information without their expressed consent. This notice has been explained to the consumer or legally responsible person.

2. Informed Consent - The provision of services is not contingent upon such consent and of the need for such release. The consumer or legally responsible person shall give consent voluntarily.

3. Confidential information may not be disclosed without written consent when federal Statutes prohibit that release.

   42 CFR Part 2 Subpart D Disclosures without consumer or legally responsible person consent - No provision of General Statutes 122C-205 and General Statutes 122C-53 through General Statutes 122C-56 permitting disclosure of confidential information may apply to the records of a consumer when federal statutes or regulations applicable to that consumer prohibit the disclosure of this information.

4. Confidentiality information may be released without consent for the following: under court order, to an internal consumer advocate; when the consumer has left a 24-hour facility and appropriate individuals need to be notified; any suspected abuse/neglect or communicable disease; to the consumer's attorney representing the State if the consumer is facing court hearings; to Department of Corrections if the consumer is or has been imprisoned; for purposes of filing petition for involuntary commitment or adjudication of incompetence; to the agency's attorney; when there is imminent danger to the health, safety of the consumer or another consumer or when there is the likelihood of the commitment of a felony or violent misdemeanor; to healthcare provider who is providing emergency services; to another NC MH/DD/SAS facility, provider of support services, Secretary, physician or other consumers when necessary to coordinate appropriate and effective care; for approved research and planning, audits and statistical purposes.

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CONFIDENTIALITY

In general, the confidentiality of all communications between a client and assigned professional is protected by law. Contents of all services are considered confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or client's legally responsible person. However, there are a number of exceptions.

Duty to Warn and Protect

When a client discloses intention or a plan to harm another person, the Mental Health professional is required to wan the intended victim and report this information to the legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If it is believed that a child, an elder person, or a disabled person is being abused; the agency must file a report with the Child Protective Services and Adult Protective Services. If a client states or suggests that he or she is abusing a child or vulnerable adult or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, the Mental Health professional is required to report this information to the appropriate social service and/or legal authorities.

Abuse to Oneself

If a client threatens to harm him/herself, the agency may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection (police or the mobile crisis team).

Should any of the situations occur, your assigned professional would make every effort to fully discuss it with you before taking any action.

Your therapist may occasionally find it helpful to consult about a case with other professionals. In these consultations, he/she will make every effort to avoid revealing the identity of the client.

I understand the above information pertaining to confidentiality.

____

Client or Legally Responsible Person Date

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STATEMENT OF PROVIDER CHOICE

I ____ (Client/Legally Responsible Person) have selected to receive the following service(s) from Sunrise Clinical Associates, PLLC

- ☐ Community Support Team
- ☐ Diagnostic Assessment or Comprehensive Clinical Assessment
- ☐ Outpatient Therapy
- ☐ Medication Management/ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ Peer Support

Other: ____

I attest that I have been provided with the information necessary to make an informed choice about service, informed about the range of other services available; and informed about my right to receive services in a way that is non-coercive and protects my right to self determination.

My selection of a service provider was based solely upon my identified needs, diagnosis, and preference and provider availability.

By signing this Statement of Provider Choice, I acknowledge that I was given choice of provider and that during screening, location, available times, specialty, culture and linguistic preferences with me were discussed.

Client/Legally Responsible Person Signature:

____

Date: ________________

Sunrise Clinical Associates, PLLC Staff / Witness:

____

Date: ________________

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CLIENT ORIENTATION

As a client of Sunrise Clinical Associates, PLLC (SCA, PLLC), upon admission I have been explained or given written materials regarding:

- Rights and responsibilities of the person served.
- Consumer Handbook (revised 5/10/18)
- Complaint and appeal procedures.
- Ways in which input is given
- An Explanation of the agency's:
  (1) Confidentiality Policy
  (2) Intent/consent to treat
  (3) Behavioral expectations of the person served
  (4) Transition criteria and procedures
  (5) Discharge criteria
  (6) Response to identification of potential risk to the person served
  (7) Access to after hour services
  (8) Standards of professional conduct related to services
  (9) Requirements of reporting and/or follow-up for the mandated person served, regardless of his or her discharge outcome.
  (10) Cultural Competency (Multiculturalism, Anti-Racism, Anti-Stigma and Ethnic Intimidation)
- Any and all financial obligations, fees, and financial arrangements for services provided by the agency.
- The program's health and safety policies regarding;
  (1) The use of seclusion or restraint
  (2) Use of tobacco products
  (3) Illegal or legal substances brought into the program
  (4) Prescription medication brought into the program
  (5) Weapons brought into the program
  (6) Reducing identified physical risk
  (7) Infections and Communicable diseases
- The program rules and expectations of the person served, which identifies the following:
  (1) Any restrictions the program may place on the person served
  (2) Events, behaviors, or attitudes and their likely consequences
  (3) Means by which the person served may regain rights or privileges that have been restricted
- Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits.
- Education regarding advance directives, if appropriate
- Identification of the purpose and process of the assessment.
- A description of:
  (1) How the individual person centered plan will be developed
  (2) The person's participation in goal development and achievement
  (3) The potential course of treatment/services
  (4) How motivational incentives may be used
  (5) Expectations for legally required appointments, sanctions, or court notifications
  (6) Expectation for family involvement
- Identification of the person(s) responsible for service coordination.

Print Client Name: ____

____ Date:________________

Signature of Client/Legally Responsible Person

Signature of Staff____ Date: ________________

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ADDITIONAL CONSENTS / ACKNOWLEDGEMENTS

Client Name: ___________________________________ MR #: ______________

I, ____ (Client /Legally Responsible Person) do hereby agree to the following acknowledgements and consents:

1. Authorization to Provide Transportation

I understand that Sunrise Clinical Associates, PLLC is not obligated to provide transportation and further understand that employees, contractors, volunteers and agency representatives of the agency (who may transport due to an exceptional circumstance) are not responsible for any injury/damages which may be incurred. Therefore, I release, discharge and covenant not to sue above mentioned individuals or their insurers/agents. In addition, they are free from all liability, claims, losses or damages whether or not caused in whole or in part by the negligence in the connection with transportation. I also consent to emergency medical treatment in the event that I am unable to provide such consent in an emergency.

Initial ________

2. Unauthorized Leave

I understand that if the above mentioned client leaves the supervision of a Sunrise Clinical Associates, PLLC employee without permission, the closet kin along with the local law enforcement agency will be notified immediately. I do hereby release Sunrise Clinical Associates, PLLC from all liability should an accident or injury occurs.

Initial _________

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Release of Information to Third Party Payers:

I hereby authorize Sunrise Clinical Associates, PLLC to release information from my client service record to my insurance company, Medicaid or Medicare in order to process and pay claims for services rendered to me. I understand that this consent allows release of all information in my client record including, substance abuse, communicable diseases (including AIDS/HIV), and other sensitive documentation. Initial _________

3. **Least Restrictive Interventions and Alternatives to Restrictive Interventions:**

I have been explained that Sunrise Clinical Associates, PLLC prohibits the use of restrictive interventions. Only least restrictive methods, strategies and alternative activities are allowed as interventions to de-escalate aggressive behaviors during treatment. The agency promotes coping and engagement skills that are alternative to physical restraints or injurious behavior to persons served or others.

Initial ___________

4. **Consents and Right to Appropriate Services:**

I have been explained that all clients' participation in care is voluntary. All clients receiving care have the right to the least restrictive treatment and to be informed about the services they are receiving. This includes basic expectations of program participation, access to records, confidentiality, and any potential risks to program participation. Informed Consent also means that clients have information regarding the specific services to be performed, who will provide the services, and any potential risks and benefits of participation. Also, clients should be notified of any restrictions to care. Clients have a right to participate in selecting treatment providers, as well as having access to support services, advocacy groups, and 24 hour crisis services. At any point, the client may request a referral to other services. SCA, PLLC empowers clients to have a "choice" of treatment providers and can refuse services at any time.

Initial ____________

Sunrise Clinical Associates, PLLC
Consent for Treatment
Intensive In-Home Services

Intensive In-Home (IIH) services is a team approach designed to address the identified needs of children and adolescents who, due to serious and chronic symptoms of an emotional, behavioral, or substance use disorder, are unable to remain stable in the community without intensive interventions. This service may only be provided to individuals through age 20. This medically necessary service directly addresses the individual's mental health or substance use disorder diagnostic and clinical needs. The needs are evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance (as defined by DSM-5, or any subsequent editions of this reference material), with documentation of symptoms and effects reflected in the Comprehensive Clinical Assessment and the Person Centered Plan (PCP). This team provides a variety of clinical rehabilitative interventions available 24 hours per day, 7 days per week, 365 days per year.

This is a time-limited, intensive child and family intervention based on the clinical needs of the individual. The service is intended to accomplish the following: (1) reduce presenting psychiatric or substance use disorder symptoms; (2) provide first responder intervention to diffuse current crisis; (3) ensure linkage to community services and resources; and (4) prevent out of home placement for the individual.

IIH services are authorized for one individual child in the family. The parent or caregiver must be an active participant in the treatment. The team provides individualized services that are developed in full partnership with the family. Effective engagement, including cultural sensitivity, is essential in providing services in the family's living environment. Services are generally more intensive at the beginning of treatment and decrease over time as the individual's skills develop.

This team service includes a variety of interventions that are available 24-hours-a-day, 7-days-a-week, 365-days-a-year. Services are delivered by the IIH staff who maintain contact and intervene as one organizational unit. IIH services are provided through a team approach; however, discrete interventions may be delivered by any one or more team members as clinically indicated. Not all team members are required to provide direct intervention to each individual on the caseload. The team leader must provide direct clinical interventions with each individual. The team approach involves structured, face-to-face, scheduled therapeutic interventions to provide support and guidance across multiple functional domains including emotional, medical and health. This service is not delivered in a group setting.

In partnership with the individual, the individual's family, and the legally responsible person, as appropriate, the licensed clinician (Team Leader) or Qualified Professional is responsible for convening the Child and Family Team, which is the vehicle for the person-centered planning process. The licensed clinician or Qualified Professional consults with identified medical (such as primary care and psychiatric) and non-medical providers (e.g., the county department of social services (DSS), school, the Department of Juvenile Justice and Delinquency Prevention (DJJDP), engages community and natural supports, and includes their input in the person-centered planning process.

IIH is a direct and indirect periodic rehabilitative service in which the IIH members provide medically necessary services and interventions that address the diagnostic and clinical needs of the individual. Additionally, the team provides interventions with the family and caregivers on behalf of and directed for the benefit of the individual as well as plans, links, and monitors services on behalf of the individual. This service is provided in various environments, such as homes, schools, courts, homeless shelters, libraries, street locations, libraries, and other community settings.

Potential Risks of Participation: While the goal of IIH is to help the child or adolescent improve functioning to reduce the likelihood of out-of-home placement, it is important to recognize that change on the individual and family level is difficult. Sometimes, it is hard to talk about mental health or substance use disorders, as well as the impact these have had on your life and family. In addition, staff may ask questions about your history and life experiences that are difficult to share. Please let staff know if you feel uncomfortable at any time.

Potential Benefits of Participation: Potential benefits include increased functioning, improved communication and progress on identified goals. Another potential benefit is working together with Sunrise Clinical Associates, PLLC in building a team to support you through this process.

Informed about Services and Interventions: Sunrise Clinical Associates, PLLC does not condone the use of experimental interventions or medications. You have a right to be informed about the potential risks and benefits of all services and interventions provided by Sunrise Clinical Associates, PLLC.

Sunrise staff will protect your confidentiality at all times.

Refusal of treatment cannot be used as the sole grounds for termination or threat of termination of services unless the treatment/service is the only viable treatment/service option available at Sunrise Clinical Associates, PLLC.

By signing this form, I consent to receive Intensive In-Home Services. This consent is valid for one year.

Consumer Signature ____________________________________ **Date:** ________________

Legally Responsible Person Signature _______________________________________ **Date:**________________

Staff/Witness Signature: ____ **Date:** ________________

Sunrise Clinical Associates, PLLC

Consent to Audio Recording & Transcription

I, ___________________________ (client / parent or guardian) consent to the audio recording of my Intensive In-Home sessions with Sunrise Clinical Associates, PLLC. These recordings will be reviewed with discretion by the developers of my identified Evidenced Based Practice and will not be released to another party without additional written consent. All recordings will be destroyed after review.

The audio recording(s) shall be used for treatment evaluations purposes only. Outcomes/results from the audio recording shall be used to encourage, support and improve standards of mental health initiatives.

- The purpose and value of recording have been fully explained to me.
- I understand that I will not receive financial compensation for the use of these audio recordings.
- I understand that I will not be punished in any way if I refuse to have my sessions audio recorded.
- I understand that Sunrise Clinical Associates, PLLC is bound by laws and professional rules about consumer's' privacy.

By signing this form, I freely and willingly consent to audio recording. This consent is valid for one year.

____ ________________

Signature of Client or Legally Responsible Person Date

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Participation in Treatment (Intensive In-Home Services) Agreement

I, ____, understand and agree to be a participatory caregiver
Caregiver/Guardian's Name

in _______________________________________ treatment as required by the Managed Care
Client's Name

Organization (Alliance Behavioral Healthcare) and developer of the applied treatment modality.

I understand that my commitment and involvement will assist in producing better outcomes, improved behavior/mental well-being, healthier family interactions and sustained behavioral improvements upon discharge.

By signing this form, I agree to be available to the team for pre-scheduled sessions as needed, provide feedback and participate in Child and Family Treatment Team meetings.

____________________________________	___________________________________	___________
Caregiver/Guardian Print Name	**Caregiver/Guardian Signature**	**Date**
____________________________________	___________________________________	___________
Caregiver/Guardian Print Name	**Caregiver/Guardian Signature**	**Date**
____________________________________	___________________________________	___________
Staff Print Name	**Staff Signature**	**Date**

Consent for Treatment

Outpatient Therapy

(Outpatient Behavioral Health Services)

Outpatient behavioral health services are psychiatric and bio-psychosocial assessment, medication management, individual, group, and family therapies, psychotherapy for crisis, and psychological testing for eligible individuals.

These services are intended to determine a beneficiary's treatment needs, and to provide the necessary treatment. Services focus on reducing psychiatric and behavioral symptoms in order to improve the individual's functioning in familial, social, educational, or occupational life domains.

Outpatient behavioral health services are available to eligible individuals and often involve the participation of family members, significant others, and legally responsible person(s) as applicable, unless contraindicated.

Based on collaboration between the practitioner and individual, and others as needed, the individual's needs and preferences determine the treatment goals, frequency and duration of services, as well as measurable and desirable outcomes.

Outpatient Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, outpatient therapy has also been shown to have benefits for individuals who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Not everyone is a good candidate for outpatient therapy and the treatment may not be effective in all cases.

CONSENT FOR TREATMENT

I authorize and request Sunrise Clinical Associates, PLLC to carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

Sunrise staff will protect your confidentiality at all times.

Consent for Treatment

Outpatient Therapy

(Outpatient Behavioral Health Services)

Refusal of treatment cannot be used as the sole grounds for termination or threat of termination of services unless the treatment/service is the only viable treatment/service option available at Sunrise Clinical Associates, PLLC.

I understand and agree to all of the above information. By signing this form, I consent to receive Outpatient Therapy. This consent is valid for one year.

____

Signature of client /Legally Responsible Person / Date Printed Name

____

Staff Signature / Date Printed Name

Sunrise Clinical Associates, PLLC

Consent for Treatment
Assessment
(Diagnostic Assessment or Comprehensive Clinical Assessment)

A Diagnostic Assessment or Comprehensive Clinical Assessment is an intensive clinical and functional face-to-face evaluation of an individual's mental health, intellectual and developmental disability, or substance use condition. The assessment results in the issuance of a Diagnostic Assessment or Comprehensive Clinical Assessment report with a recommendation regarding whether the individual meets target population criteria and includes a recommendation for Enhanced Benefit services that provides the basis for the development of the Person Centered Plan. For substance use-focused Diagnostic Assessment or Comprehensive Clinical Assessment, the designated diagnostic tool specified by DMH (e.g., Substance Use Disorders Diagnostic Scheduled (SUDDS) IV, Addiction Severity Index (ASI), Substance Abuse Subtle Screening Inventory (SASSI) for specific substance use disorder benefit plan populations (i.e., Work First, Driving While Intoxicated (DWI), etc. must be used. In addition, any elements included in this service definition that are not covered by the tool must be completed.

Elements of the Diagnostic Assessment or Comprehensive Clinical Assessment:

a. a chronological general health and behavioral history (includes both mental health and substance use) of the individual's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;

b. biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;

c. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions; and current medications;

d. a strengths or problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;

e. diagnoses from the DSM-5, or any subsequent editions of this reference material, including mental health, substance use disorder and or intellectual/developmental disability as well as physical health conditions and functional impairment;

Sunrise Clinical Associates, PLLC

Consent for Treatment
Assessment
(Diagnostic Assessment or Comprehensive Clinical Assessment)

f. evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;

g. a recommendation regarding target population eligibility; and

h. evidence of individual participation including families, or when applicable, guardians or other caregivers.

Refusal of treatment cannot be used as the sole grounds for termination or threat of termination of services unless the treatment/service is the only viable treatment/service option available at Sunrise Clinical Associates, PLLC.

By signing this form, I consent to receive a Diagnostic Assessment or Comprehensive Clinical Assessment. This consent is valid for one year.

Consumer Signature: ______________________________ Date: _________

Legally Responsible Person Signature: ________________________________ Date: __________

Sunrise Clinical Associates, PLLC

Consent for Psychiatric Evaluation and Medication Management

Medication Management is a core service for individuals (children/adolescents and adults with mental health, substance abuse and co-occurring illness).

Medication Management is the standard of care that ensures each consumer medication (whether they be prescription, nonprescription, alternative, traditional, vitamins or nutritional supplements) are individually assessed to determine that each medication is appropriate for the consumer, safe given the co-morbidities and other medications being taken, and able to be taken by the consumer as intended.

Medication Management is the level of outpatient treatment where the sole service rendered by a qualified physician, or others whose scope of practice includes prescribing medication, is the initial evaluation of the consumer's need for psychotropic medications, the provision of a prescription, and, as-needed, ongoing medical monitoring/evaluation related to the consumer's use of psychotropic medication. Interactive psychotherapy is not being rendered at this time by the physician/prescriber, but may be provided by another clinician.

Service Expectations

- Psychiatric Evaluation
- Medical evaluation
- Medication monitoring routinely and as needed
- Consumer education pertaining to the medication to support the individual in making an informed decision for its use.
- Sunrise Clinical Associates, PLLC shall make a good faith attempt to coordinate care with the individual's primary care physician.

Sunrise staff will protect your confidentiality at all times.

Refusal of treatment cannot be used as the sole grounds for termination or threat of termination of services unless the treatment/service is the only viable treatment/service option available at Sunrise Clinical Associates, PLLC.

By signing this form, I consent to receive Psychiatric Evaluation and Medication Management. This consent is valid for one year.

Consumer Signature: ____ Date: ______________

Legally Responsible Person Signature: __________________________ Date: ______________

Staff/Witness Signature: ____________________________________ Date: ______________

Revised 11/10/15; 4/29/19

Sunrise Clinical Associates, PLLC

Consent to Psychological Testing and Evaluation

I, ___________________________ (client / parent or guardian) agree to allow the evaluator (Sunrise Clinical Associates, PLLC) to perform psychological testing and evaluation.

I understand that psychological testing is an interactive process between the consumer and evaluator. It is meant to promote understanding and treatment planning. Psychological testing involves the culturally and linguistically appropriate administration of standardized tests to assess a recipient's psychological or cognitive functioning. Testing results must inform treatment selection and treatment planning; recommendations for type, duration, frequency or amount of rehabilitative services. Sometimes the process can be emotionally painful and other times it may be fulfilling.

I understand that these services will include direct, face-to-face contact, interviewing or testing. The service may also include the evaluator's time required for the reading of records, consultation with other psychologists and professionals, scoring, interpreting the results and any other activities to support these services. I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

I also understand the evaluator agrees to the following:

- The procedures for selecting, giving, and scoring the tests, interpreting and storing the results, and maintaining my privacy will be carried out in accordance with the rules and guidelines of the American Psychological Association and Health Insurance Portability and Accountability Act (HIPAA).

- Tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.) These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines.

- Tests and test results will be maintain in a safe location.

My signature below confirms that I have read the above and hereby seek and consent to take part in the psychological testing and evaluation.

By signing this form, I freely and willingly consent to psychological testing and evaluation. This consent is valid for one year.

______________________________________ ________________

Signature of Client or Legally Responsible Person Date

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ACKNOWLEDGEMENT WHETHER RECEIVING ADDITIONAL SERVICES FROM ANOTHER PROVIDER AGENCY

In order to ensure Sunrise Clinical Associates, PLLC is appropriately rendering adequate duration of services, we must receive acknowledgement if you are receiving services from another mental health agency or agencies.

☐ I am currently not receiving services from another provider agency.

☐ I am currently receiving services from another provider agency.

Please specify agency name(s) and service(s) being provided.

____

____

Client/Legally Responsible Person Signature:

____

Date: ________________

Sunrise Clinical Associates, PLLC

3500 Westgate Drive, Suite 604, Durham, NC 27707 Office: (919) 493-5013 Fax: (919) 493-5026

Date: ___________

Name of Primary Care Physician, Community Health Center or Clinic

____
____
____

Dear ______________________________________:
Primary Care Physician, Community Health Center or Clinic

I would like to introduce myself as a physician at Sunrise Clinical Associates, PLLC. My name is Dr. Sampson Harrell.

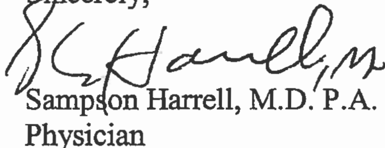
______________________, a patient of yours, has recently expressed an interest in our Behavioral
Recipient
Health Services. Their services will require coordination and communication with you, as the identified primary care physician, community health center or clinic.

The recipient is currently receiving ______________________. We will continue to keep you updated with any services and/or medication changes that may occur in order to better meet the Medical and Behavioral Health needs of the recipient. I have enclosed a disclosure form that will allow you to release any documentation that may be imperative to the recipient's well-being. Sunrise Clinical Associates, PLLC would greatly appreciate your participation in this matter.

This recipient has signed an authorization form allowing us to exchange pertinent information with you.

If you have any further questions regarding this case, or if you have further information that you think might assist us in better meeting this recipient's clinical needs, please feel free to contact me at (919) 493-5013.

Sincerely,



Sampson Harrell, M.D. P.A.
Physician

Enclosed: Authorization of Release of Information form for ___________________________
Recipient

Consumer Name: **DOB:** **Record #:** **Medicaid #:**

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

☐ I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.

☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.

☐ For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes ☐ No ☐

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

Signature: ______________________ ______________________ Date: __/__/____

(Print Name)

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

Signature: ______________________ ______________________ Date: __/__/____

(Print Name)

Relationship to the Individual: ______________________

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

Signature: ______________________ ______________________ Date: __/__/____

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

Child Mental Health Services Only:

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

☐ Met with the Child and Family Team - Date: __/__/____

☐ **OR** Child and Family Team meeting scheduled for - Date: __/__/____

☐ **OR** Assigned a TASC Care Manager - Date: __/__/____

☐ **AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

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

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

Signature: ______________________ ______________________ Date: __/__/____

(Person responsible for the PCP) (Print Name)

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

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

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

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

Signature: ______________________ ______________________ License #: ________ Date: __/__/____

(Name/Title Required) (Print Name)

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

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

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

☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.

☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.

☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: ______________________ ______________________ License #: ________ Date: __/__/____

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

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): ______________________ Date: __/__/____

Other Team Member (Name/Relationship): ______________________ Date: __/__/____

SUNRISE CLINICAL ASSOCIATES, PLLC **(revision 1/3/18)**

Client: ___________________________________ Record Number: ____________________ DOB: __________

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

THE BELOW SECTION IS TO IDENTIFY THE INDIVIDUAL, AGENCY AND PROVIDER WHO IS TO RECEIVE THE INFORMATION (PLEASE DO NOT WRITE THE CLIENT'S OR LEGALLY RESPONSIBLE PERSON'S NAME!!!!)

(Write the name of individual, agency or provider that will receive or obtain protected health information on the client). Name of individual, agency or provider:
Address:
Phone:
Fax:

This authorization form implements the requirements for client's or legally responsible person's authorization to use and disclose health information protected by:

- Federal Health Privacy Law, 45 CFR Parts 160, 164
- Federal Drug and Alcohol Confidentiality Law, 42 CFR, Part 2
- North Carolina State Confidentiality Law governing mental health, developmental disabilities, and substance abuse services, NC GS 122C.

I ____________________________________ hereby request and authorize, Sunrise Clinical Associates, PLLC
(Client or Legally Responsible Person)
to disclose/exchange specified health information from the records of the above named client for the specific purpose(s) and reason(s): **MUST BE SPECIFIC – DO NOT WRITE "COORDINATION OF CARE"**

____

____

Individualized specific information to be released must be provided. The information to be disclosed / exchanged may include the following protected information: (please specify). If other is checked, write a description of the information to be disclosed / exchanged.

☐ History and Physical	☐ Psychiatric Evaluation	☐ PCP/Treatment Plan
☐ Screening Assessment	☐ Hospital Summary	☐ Progress Notes
☐ Intake Documents	☐ Physical Exam	☐ Diagnoses
☐ Current Medications	☐ Discharge Summary	☐ Legal Information
☐ Insurance Benefits/Claims	☐ Academic Information Classroom Behavior	☐ Laboratory Reports
☐ Alcohol & Drug Treatment Summary	☐ Other – Specify ______________________________ ______________________________	

Unless you sign here, NO information about alcohol/substance abuse, HIV/AIDS will be disclosed:
Yes, Disclose this information____
No, Do Not disclose this information______________________________________

SUNRISE CLINICAL ASSOCIATES, PLLC

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

____ **(NOT TO EXCEED ONE YEAR)**

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the ***Revocation Section*** on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

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

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

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

SIGNATURES

_________________________________ ___________ _____________________________________

Signature of Client Date Witness- if required

_________________________________ ____________ _____________________________________

Signature of Parent, Legally Responsible Person, Personal Representative Date Relationship/Authority

SUNRISE CLINICAL ASSOCIATES, PLLC

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of ______________________________
(Name of Client)

signed by____ on ____________________________
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective ________________(date). I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

_____________________________	_______________	_______________________	_____________
Signature of Client	Date	Signature of Witness	Date
_____________________________	_______________	_______________________	_____________
Signature of Parent, Legally Responsible Person, Personal Representative	Date	Relationship/Authority	Date

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by

____

on _________________ (date). The client or his/her personal representative has been informed that any action taken on this authorization prior to the rescinded date is legal and binding.

_____________________________	_______________	_______________________	_____________
Signature of Staff	Date	Signature of Witness	Date

NOTE: This Authorization was revoked on: ________________ Date ___________________________________ Signature of Staff

SUNRISE CLINICAL ASSOCIATES, PLLC
3500 Westgate Drive, Suite 604, Durham, NC 27707-2567 • Office: (919) 493-5013 • Fax: (919) 493-5026

Transition/Reauthorization Planning Form (revised 9/15/17)

______________________________________ ____________________

Client or Legally Responsible Person **Date**