CONSENT FOR TREATMENT

The rates, policies regulations, services and statutory provisions concerning client rights have been explained to me. I understand that, as an individual, I shall receive appropriate evaluation and treatment by ACTS.

OUTPATIENT TREATMENT

I request admission to ACTS for evaluation and/or treatment. Should the clinical staff determine admission to outpatient services appropriate, I consent to treatment including alleged benefits, potential risks and possible alternate methods of treatment deemed necessary. I understand that I may refuse the clinical services at any time.

I fully understand the above statement that has been read and explained to me by a member of the treatment staff.

Follow up: I understand that I will be contacted after termination from treatment for the purpose of tracking client’s progress/outcome.

CONFIDENTIALITY OF SERVICE RECORD

The confidentiality of records maintained by ACTS is protected by State and Federal Law. Generally, the employees may speak to a person outside the program or disclose any information identifying an individual except in accordance with GS 122 C52 through 122 C56 or Federal Register 42CFR Part 2. Some examples are:

- The client consents in writing.
- The disclosure is allowed by a court order.
- The disclosure is made in a medical emergency.
- The disclosure is made when imminent danger to the health or safety of the individual or another is suspected or there is likelihood that a felony or misdemeanor will occur.
- The disclosure is made to qualified personnel for research, audit or program evaluation.

Violation of the Confidentiality Requirements is considered a crime. Suspected violation may be reported in accordance with the law. Confidentiality laws and regulations do not protect any information about a crime committed by an individual either at the program or about any threat to commit such a crime. Confidentiality laws and regulations do not protect any information about suspected child abuse or neglect from being reported to appropriate authorities.

CLIENT RIGHTS ACKNOWLEDGEMENT

I have read or have had read to me the Client Rights Rules and Regulations.

Further, my therapist/counselor has discussed the brochure with me and I understand my rights as a client at the Center.

A copy of the Rules and Regulations has been given to me by ACTS staff at the time of admission, within my first three visits to the agency or within my first 72 hours when in a 24 hour facility.

I understand that this brochure only provides information about my rights, but does not constitute legal advice or findings with respect to those rights, and should not be considered as granting or denying any right guaranteed by law.

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT FORM

ACTS is required by the Health Information Portability and Accountability Act (HIPPA) of 1996 to maintain the privacy of your health information as stated in our Notice of Privacy Practices.

- I understand that the Notice of privacy practices discusses how my personal health information may be use and/or disclosed without my knowledge or permission.
- I may review a copy of the Notice of Privacy Practices in the waiting room of the agency.
- I understand that the terms of the Notice of Privacy Practices may be changed in the future, and these changes will be posted in each service delivery site in visible areas. I may also request a copy of the new Notice of Privacy by contacting the Privacy Officer at (910) 438-0939.

ADVANCED DIRECTIVE

I have been informed about my rights to make an Advanced Directive as described in the Client Rights brochure. If I choose to take a packet, I understand that I may ask trusted professionals, family members or friends to assist me in completing this legal document. I also understand that I may ask trusted professionals, family members or friends to assist me in completing this legal document. I also understand that I may ask trusted professionals, family members or friends to assist me in completing this legal document. I also understand that I may ask trusted professionals, family members or friends to assist me in completing this legal document.

I understand that the Advance instruction I give may be revoked at any time by a written or verbal order as long as I order revocation while my condition is mentally and/or medically stable.

Client/Legal Guardian Signature: ___________________________ Date: ___________________________

Witness Signature: ___________________________ Date: ___________________________

Revised 11/08/07 form #107
As a client of Alternative Care Treatment Systems, upon admission I have been instructed in or given written materials regarding:

- Rights and responsibilities of the person served.
- Grievance and appeal procedures.
- Ways in which input is given regarding:
  a) The quality of care.
  b) Achievement of outcomes.
  c) Satisfaction of the person served.
- An explanation of the organization's:
  1) Services and activities.
  2) Expectations.
  3) Hours of operation.
  4) Access to after-hour services.
  5) Code of ethics
  6) Confidentiality policy.
  7) Requirements for follow-up for the mandated person served, regardless of his or her discharge outcome.
- An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization.
- Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits.
- The program's policies regarding:
  1) The use of seclusion or restraint.
  2) Smoking.
  3) Illicit or licit drugs brought into the program.
  4) Weapons brought into the program.
  5) Abuse and neglect.
• Identification of the person responsible for service coordination.

• A copy of the program rules of the person served that identifies the following:
  1) Any restrictions the program may place on the person served.
  2) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the person served.
  3) Means by which the person served may regain rights or privileges that have been restricted.

• Education regarding advance directives, if appropriate.

• Identification of the purpose and process of the assessment.

• A description of how the individual plan will be developed and the person's participation in it.

• Information regarding transition criteria and procedures.

• When applicable, an explanation of the organization's services and activities include:
  1) Expectations for consistent court appearances.
  2) Identification of therapeutic interventions, including:
     a) Sanctions.
     b) Interventions.
     c) Incentives.
     d) Administrative discharge criteria.

Client's Name: ____________________________________________

_________________________________________________________

Signature of Client

_________________________________________________________

Print Name

Date: _______________
WAIVER OF TRANSPORTATION LIABILITY

I understand that Alternative Care Treatment Systems Inc., does not provide a transportation service and further;

(A) I, understand that the driver, vehicle owner, Alternative Care Treatment Systems, Inc., its employees, insurers, directors, agents, officers, volunteers and contractors are not responsible for any injury / damages which may be incurred during the course of transport, and in consideration for providing transportation, I release, discharge, and covenant not to sue Driver, Alternative Care Treatment Systems, Inc. or their insurers, directors, agents, officers, volunteers, employees and other representatives (each considered one of the Releases herein) from all liability, claims, demands, losses, or damages on Owner's account whether or not caused in whole or in part by the negligence of the Releases in connection with the transport.

(B) I, agree to hold Alternative Care Treatment Systems, Inc., its employees, insurers, directors, agents, officers, volunteers and contractors as well as the drivers and owners of the vehicles providing transportation, harmless from claims for injury or damages occurring during the trip.

__________________________  __________________
Client Signature               Date

__________________________
Print Name

Record Number:____________________
CLIENT CHOICE AND REFERRAL ACKNOWLEDGEMENT FORM

Date: __________________________

Client ID: __________________________ Client Name: __________________________

Client was given the following provider choices: □ Listed Below □ See attachment

__________________________________________________________________________

__________________________________________________________________________

Provider Chosen:

Reason(s) Provider was Chosen:

□ Hours
□ Location
□ Specialties
□ Age Group Specialty
□ Payer Source
□ Special Accommodations
□ Language
□ Other

Client Comments

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Client Concerns

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

By signing below, I acknowledge that I was given choice of provider and that the screening discussed location, available times, specialty, culture and linguistic preferences with me.

Client Signature: __________________________
Access Screener: __________________________
Release of Information & Authorization To Leave Recorded Communications

Thank you for choosing Alternative Care Treatment Systems for your medical needs. In order to serve you fully and effectively,

WE NEED YOUR PERMISSION TO;
- Leave a message on your home telephone recorder
- Personal mobile device.
- Voice messaging system on internet based messaging system (VOIP)
- Or any system that records and relays messages.

PLEASE BE AWARE that someone other than YOU may have access to this recorded information therefore if you DO NOT want this information left on any type or form of recording device please place an "X" on the appropriate line below and sign.

WE WILL ONLY LEAVE INFORMATION THAT PERTAINS TO*:
- Rescheduling an appointment(s).
- Reminder of next day appointment(s).
- Inclement weather, which may affect our business hours.
- Any emergency situation that may arise that concerns your appointment(s).

___ YES, I authorize ACTS.inc to contact me and leave a message(s) that may pertain to anything listed above.
___ YES, I authorize ACTS.inc to leave a message with whomever answers the phone number we have on file to contact you.
___ NO, I do not want ACTS.inc to contact me and leave a recorded message(s) or leave message with anyone other than myself.

IN ADDITION:
___ YES, May we refer to you by “your first name” when you are waiting in our lobby to be seen for an intake, appointment etc.
*We will not leave personal medical information. As a part of HIPPA (Health Information Privacy Act) requirement, we are required to gather this information before sharing any information about you.

__________________________________________
PRINT NAME
__________________________________________
SIGN NAME
__________________________________________
DATE
__________________________________________
CONTACT/PHONE NUMBER

Mental Health, Developmental Disabilities & Substance Abuse Services