New Patient Notice and Consent Form

Consent For Services Agreement

Individual: _____Record#: _____ Medicaid# _____DOB: _____

I, _____, (consumer of service or Legally Responsible Person [if child is a minor or in DSS, DJJ custody]) give consent to:

_____1. To receive and/or for the above consumer to receive services from R&R Perspectives, LLC, I (we) understand that developing a Person Centered Plan with staff and regularly reviewing our work toward meeting the goals are in my (our) best interest. I (we) agree to play an active role in this process. I (we) understand that no promises have been made to me (us) as to the results of treatment or of any procedures provided by the R&R Perspectives, LLC staff. I (we) agree to report to R&R Perspectives, LLC staff any obstacles that may impede my progress in treatment.

_____2. I acknowledge that this service is voluntary and that I (may/may not due to court order) may discontinue services at anytime.

_____3: I agree to allow R&R Perspectives, LLC staff to provide accepted methods of intervention (NCI or its equivalent, when warranted) as indicated by the client's mutually agreed upon treatment goals identified in my Person Centered Plan.

Do you wish to be notified when a therapeutic intervention is used? ☐Yes ☐No
Please list name and telephone number of individual(s) to be notified:

___4: The Confidentiality policy has been explained to me (us), and I (we) understand that my (our) consent is voluntary and may be revoked by me (us) at any time. I (we) understand the agency policies protecting the confidentiality of this client.

___5: Agree to the use of Therapeutic Crisis Intervention procedures as they have been explained to me.

___6: Agree that this document may be amended on an as needed basis, and that any such amendment will require the signature of the client's parent/guardian, social worker/community support worker, court officer and/or court counselor.

____7: Agree to allow observation of this client by professionals and trainees in such areas as teaching psychology and social work, as well as observations by groups that may tour the program, with the understanding that measures will be taken at all times to protect the client's right to confidentiality. These measures will include, but not be limited to an explanation of client rights and confidentiality and a signed confidentiality agreement to be maintained in the program files.

____8: Agree to allow this client to be photographed, audio taped and/or videotaped, but only for treatment or training/supervision purposes and only for use by R&R Perspectives, LLC staff and members of client's treatment team. I (we) understand that photographing, audio taping and/or videotaping if this client for any purpose or audience other than those defined above shall require my (our) additional written consent. Finally, I (we) understand that confidentiality will be guaranteed in the use of this material.

Consent for Release of Confidential Information

I authorize **R&R Perspectives, LLC** *in case of emergency to disclose pertinent information to* the emergency Contact Person that I've listed on the Face Sheet *the circumstances surrounding the emergency event*. Purpose of this disclosure is to **inform appropriate parties of an emergency situation which may arise while I am in treatment.**

I also authorize R&R Perspectives, LLC to disclose any Medical History/Allergies to, if applicable, any Emergency Medical Personnel and/or my Primary Care Physician.

Lastly, if needed, I would like to seek emergency medical assistance at the hospital listed on the Face Sheet and authorize R&R Perspectives personnel to submit any needed information that will aid the emergency medical assistance to appropriately assess my or my child's needs.

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I understand that while my child or I are receiving services from R&R Perspectives, LLC, they will ask me periodically to give current information in order to update any contacts and numbers previously supplied.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Other Drug Abuse Patient Records, 42 CFR. Part 2 and HIPPA and cannot be disclosed without my written consent unless otherwise provided for in the regulations. **I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event the consent expires automatically as follows: When the emergency situation has passed and/or when information has been conveyed to those named.**

24hr First Responder Service

I have been informed that R&R Perspectives, LLC provides a 24 hour, 7 day a week, 365 days per year, emergency telephone number (704) 668-4505 for the use for clients and/or family members in crisis situations. The qualified professional answering this phone number will be able to provide crisis intervention up to and including face-to-face services. Furthermore, I have been given this number and was encouraged to post it along with my Crisis Intervention Plan for emergency accessibility when needed.

Client Grievance and Complaints

Persons served will be fully informed of the grievance procedures during their orientation to services. In addition, they will receive printed materials that will provide an overview of this process for later reference. The individual must make the complaint verbally or in writing at any given time he/she deems necessary. A concern could become a grievance, and a grievance requires further investigation. To be processed according to the R&R Perspectives, LLC grievance procedure, alleged abuse, neglect, or exploitation must have occurred while the individual was receiving services through R&R Perspectives, LLC. A grievance may be submitted verbally or in writing, and the individual(s) filing the grievance will be given a copy of the R&R Perspectives, LLC grievance procedure at the time of filing. All grievances/complaints will be sent to the agency's Client's Rights Committee.

As a client, you have the right to report any grievances or complaints. If you feel that your rights have been violated, or have experienced neglect or abuse, call the Disability Rights of NC at the toll free number listed below:

Disability Rights of NC
www.disablityrightsnc.org
1-800-821-6922

My signature below states that I understand all sections of this form and that I was given an opportunity to ask questions. I have also been given a copy of this Form.

Consumer's Signature (Parent/Guardian) and Date: _____

Renewed & Restored Staff and Date:

_____