ALASE Center for Enrichment II

Helping to Heal Minds, Hearts and Souls

**INFORMED CONSENT**

1. I (we) give consent for this consumer to be admitted to services provided by Alase Center for Enrichment (ACE) and in so doing agree to abide by the terms as outlined by the program.
2. I (we) acknowledge that this service is voluntary and that I (we) may at any time refuse services.

3. I (we) agree to allow ACE’s staff to implement regular and accepted methods of intervention as indicated by the consumer’s mutually agreed upon treatment/goal plan.
4. I (we) understand that physical restraint or other hands on interventions are not utilized by this practice, and that the police may be contacted if my behavior warrants.

5. I (we) grant permission for this consumer to participate in ACE’s activities with the knowledge that if such requires his/her being transported away from his/her residence. I (we) agree not to hold ACE. liable in the event of an accident of injury.
6. I (we) authorize the staff of if ACE to provide and render first aid assistance in any required situation.
7. I (we) agree to allow observations of this consumer by professionals trained in such areas as teaching psychology and social work, with the understanding that measures will be taken at all time to protect the consumer’s right to confidentiality.
8. I (we) agree to allow this consumer to be photographed but only for identification records by ACE, and diagnostic or therapeutic purposes. I (we) understand that confidentiality will be guaranteed in the use of this material, that I (we) are not required to give permission in order for this consumer to receive services, and that I (we) may revoke consent at any time by amending this Admission Agreement.
10. I (we) understand that we have the right to participate in the development of the plan of services to be offered, and to be informed of the expectations of all parties involved in the implementation.

11. Exceptions and additions to consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. I (we) agree that this document may be amended on an as-needed basis, and that any such amendment will require the signature of the consumer’s parent/guardian and duly authorized personnel of ACE. This consent will expire one year after the date it is signed.

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my consent ACE or .to provide the following service(s) for the above named consumer: Please circle and/ or check appropriate service.

\_\_\_Psychological Testing

\_\_\_Comprehensive Clinical Assessments

\_\_\_Outpatient Therapy

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

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**PERMISSION TO TRANSPORT EMERGENCY MEDICAL CONSENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**,** client/parent/legal guardian hereby gives permission for the staff of Alase Center for Enrichment (ACE) to transport and to sign Consent for Emergency Medical care for the following individual: \_\_\_\_\_\_\_\_\_\_\_\_\_**.**

It is understood that the ACE worker will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation. This consent will be valid for this time period only, not to exceed one year:

**EMERGENCY MEDICAL CARE CONTRACT**

This is also an Authorization Contract for Emergency Medical Care between the Parent/Legal Guardian and Securing Resources for Consumers, Inc. This Authorization Contract shall include the following:

1. In the event of an emergency, I hereby authorize the personnel of Alase Center for Enrichment (ACE) Inc. to take the consumer to Durham County Regional Hospital, Duke Medical University Center, UNC Chapel Hill, or the nearest hospital, if the ACE staffs deem it necessary.
2. In the event of an emergency, I hereby authorize the personnel of ACE to call the local emergency rescue unit for transportation of the consumer to the nearest local hospital.
3. I further understand that I will assume financial responsibility for any necessary medical care (not covered by Medicaid or Insurance Carrier), including payment of ambulance service.

 This consent will be valid for this time period only, not to exceed one year:

***Dates and Signatures provided below denote agreement with the Emergency Medical Consent as well as the Emergency Medical Care Contract***.

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Please initial if you do not wish to be transported during emergency situations.**

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|  |  |  |
| --- | --- | --- |
|  | **ACKNOWLEDGEMENT** |  |

 I have received copies of the following which have been explained to me so that I understand them:

I have been offered a copy of the Consumer Handbook. Additionally, the handbook contains the following information which have been explained to me so that I understand them:

|  |  |
| --- | --- |
| X Notification of Consumer Rights | X Notification of Consumer Responsibility Agreement |
| X Notification of Privacy Practices | X Notification of Complaint/Grievance Policy/Procedure |
| X Notification of Suspension/Expulsion Policy | X Notification of Search/Seizure Policy |

* I understand my rights and responsibilities as described in the Notification of Consumer Rights and the Consumer Rights Handbook.
* I understand my responsibilities as described in the Consumer Responsibility Agreement.
* I understand my protections regarding disclosure of confidential information as explained in the Notification of Privacy Practices.
* I understand the use of the Authorization f or Use and Disclosure of Protected Health Information Form. I understand the procedure for obtaining access to, or a copy of my medical record.
* I understand the procedures for ACE fee assessment and collection practices.
* I understand the ACE Suspension/Expulsion Policy and the ACE Search/Seizure Policy.
* I understand the ACE Consumer Complaint/Grievance Procedure which includes information about the individual to contact and a description of the assistance that will be provided. I understand the role of the LME/MCO's Consumer Representative and how to contact this person. I understand my right to contact Disability Rights North Carolina (the statewide agency designated under Federal and State Law to protect and advocate for the Rights of persons with disabilities.
* We/I have read and been given an explanation of the above statements and my questions have been answered to my satisfaction. I understand that this consent is valid for the duration of treatment, or until the time that I revoke this consent.

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

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 **RELEASE OF INFORMATION TO AUTHORIZED REPRESENTATIVE**

Alase Center for Enrichment (ACE) and/or any professional representing this Agency shall provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with notification of your diagnosis, the medications prescribed (dosage and side effects) and your progress towards goals (next of kin/family member/designee).

Your consent must be provided

* + - * 1. Orally, in the presence of a witness selected by you, prior to the release of this information; or
				2. In Writing; and
				3. This consent is valid for one year and subject to revocation by you, your legal guardian and/or legally responsible person.

ACE may disclose your admission/discharge to your next of kin when determined that the disclosure is in your best interest. The professional shall notify next of kin/family member/designee after the request of the individual, notification of admission to facility, transfer to another facility, decision to leave the facility against medical advice, discharge, and referrals/appointments.

It is the responsibility of ACE to respond to a written request of the next of kin/family member/designee who has a legitimate role in the therapeutic services offered to you, providing:

1) Provide the information requested based upon determination that providing this information will be to the your therapeutic benefit and provided that you or your legally responsible party has consented in writing to the release of the information requested; or

2) Refuse to provide the information requested based upon the responsible professional’s determination that providing this information could be detrimental to the therapeutic relations between the consumer and the professional; or

3) Refuse to provide the information requested based upon the responsible professional’s determination that the next of kin/family member/designee does not have a legitimate need for the information requested.

The foregoing NOTICE has been received in writing. Signature below indicates my understanding of the NOTICE, agreement that information disclosures should be made under such conditions, and acknowledgement of receipt of written notice.

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_