|  |
| --- |
| **Application for Services** |
| **PLEASE COMPLETE ALL PAGES.** | **DATE:**  |
| **Date of Referral:****Name**  |
|  **Last First Middle Maiden** |
| **Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Present address**  |
|  **Number Street City State Zip** |
| **How long**  | **Currently resides with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Telephone ( )**  |
| **Age of applicant \_\_\_\_ Social Security No. \_\_\_\_\_\_\_ – \_\_\_\_\_ – \_\_\_\_\_\_\_\_\_** |
| **Legal Guardian****Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Relationship to applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Name any medications you are taking, and for what condition(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Infectious Disease Yes 🢬 No🢬 If yes please specify on the line below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Name of physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **EDUCATIONAL INFORMATION** |
| **Assigned School Grade (\_\_\_\_\_) In which grade has applicant been retained? (\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** |
| **Current school:**  |
| **Has Applicant been classified as “special needs” under PL 105-17? (\_\_) If yes circle classification(s)****AU BED C/B HI EMD TMD SPD MU OI OHI SLD SLI TBI** |
| **Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_** |
| **Consumer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**EMERGENCY CONTACT FORM**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as the legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give Cosby Counseling & Consulting PLLC permission to access the following contacts in case of emergency and to provide necessary medical attention to me / my child.

**Emergency Contact Person(s)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Medical**

Preferred Physician:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Dentist:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Optometrist:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My signature below indicated that I grant Cosby Counseling & Consulting PLLC permission to contact the above named individuals in case of an emergency, sudden illness or accident. I further grant permission for Cosby Counseling & Consulting PLLC to seek emergency care for me/my child (circle one) from Emergency Services, a hospital, or a physician.

Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

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

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

Client Name:

Date: DOB: Record Number:

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release information reciprocal to and from:

Cosby Counseling & Consulting PLLC Phone: 980-522-8061\_\_\_\_\_\_\_\_\_

Address: 1554-B Union Rd Gastonia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NC\_\_\_\_\_\_\_28054\_

 (street) (city) (state) (zip code)

Information to be release: XX\_\_ Verbally \_XX\_\_ In Writing \_XX\_\_ By Fax

Specific Information to be released:

Specific Purpose: **Evaluation, Diagnosis and Treatme**nt

This consent shall be valid until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to Cosby Counseling & Consulting PLLC. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release

Client’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***CONSENT FORM***

***ACKNOWLEDGEMENT STATEMENTS***

**I have received a copy of the Consumer Handout. Its contents have been explained to me and I understand Deanna Cosby’s policy on the following:**

□**HIPAA □Consumer Handout □Client Rights □Grievance Policy □Privacy Practices/Disclosure Statement**

**□I have been informed that** Cosby Counseling & Consulting PLLC **provides a 24 hr, 7 days a week emergency telephone number (980) 522-8061 for the use of client and/or family members in crisis situations. The individual answering this phone number will be qualified to provide crisis intervention as well as face –to-face services. Furthermore, I have been given this number and will include it along with my crisis plan for emergency accessibility when needed.**

***□REQUIRED REPORTING***

Cosby Counseling & Consulting PLLC **is required by state, federal and local regulations, to report non-identifying client information to authorities. If you have any questions about this, please feel free to ask for a better understanding and refer to the Consumer Handout before you sign this document. Your signature below acknowledges receipt of this information.**

***□PERMISSION FOR TRANSPORTING AND OFF SITE ACTIVITIES***

**During the course of treatment the client may require transporting to school and events, activities in the community, outings in and out of the State of North Carolina. During these times, the client/parent/guardian agrees to release Deanna Cosby/ staff to transport the client during program hours for treatment purposed by use of personal agency vehicles. This consent is valid until separation from the program or by written termination of permission by client or parent/guardian**

***□EMERGENCY TREATMENT/EMERGERNCY INFORMATION/EMERGENCY RESTICTIVE INTERVENTION***

**In case of sudden illness/accident/emergency, I hereby give permission to** Cosby Counseling & Consulting PLLC **to seek emergency treatment on behalf of the below named client should need arise. It is understood that this treatment will be provided by a qualified medical professional, physician, and/or hospital emergency room personnel. In addition, a copy of current medications and known medical conditions and allergies may be released. Efforts will be made to contact the identified emergency contact person prior to treatment, should this be possible. I also will hold harmless** Cosby Counseling & Consulting PLLC **against any liability caused by their taking of any emergency procedures and/or contacts.**

**□I agree to the emergency procedures as outlined above**

**□I will assume the full responsibility of all incurred emergency treatment expenses**

***CONSENT FOR TREATMENT/SERVICES***

**□I agree to participate in the treatment, services and support that are provided by** Cosby Counseling & Consulting PLLC **as outlined in the client’s service plan. I have been informed informed of the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability. I have been informed of the services in terms that I can understand. I have also been informed of the alleged benefits, potential risks and possible alternative methods of treatment. I understand that Ian free to discontinue services at any time. I agree to accept the following checked services from** Cosby Counseling & Consulting PLLC**.**

 ***□ Clinical Assessment □Outpatient Therapy*  *□Group Therapy □Medication Management***

**The above consents have been read by me or to me and explained to me by an employee of** Cosby Counseling & Consulting PLLC **in simple non-technical language that all questions have been answered to my satisfaction and that I understand my rights.**

|  |  |
| --- | --- |
| ***Consumer/Guardian Signature*** | ***Date :*** |
| ***Witness Signature*** | ***Date :*** |

PROVIDER CHOICE ACKNOWLEDGEMENT

I understand that Cosby Counseling & Consulting PLLC provides services that are medically necessary. I have been informed of my right to choose a provider from a list of available agencies. I have also been additionally informed of my right to change providers at a later date in my treatment.

|  |  |  |  |
| --- | --- | --- | --- |
|  **Clinical Assessment**Access Family ServicesAlexander Youth NetworkCFCS, Inc.Cosby Counseling & Consulting PLLC |  | **SACOT**Anuvia Prevention & Recovery CenterCommunity Choices, Inc.CFCS, Inc.Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Community Support Team (Adult)**Monarch.Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | **Intensive In-home Services**Support Inc.MonarchOther:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **SAIOP**Phoenix CounselingArray of Brighter Beginnings |  | **Psychosocial Rehabilitation**Brighter Beginnings |  |
| **Psychiatric Services**Psychiatric Services of the Carolina’sSunpathMonarchOther:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | **Outpatient Therapy**Support Phoenix Cosby Counseling & Consulting PLLCbyOther:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

A sampling of providers who offer the services I seek in the area, as well as Desired Solutions & More:

**I was granted my choice of \_\_\_\_\_\_\_\_\_\_**Cosby Counseling & Consulting PLLC**\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name of Agency**

**to provide Comprehensive Clinical Assessment services. I was also asked about my cultural preferences (including my choice as consistent with my values, customs and beliefs), if the location of service delivery is appropriate and did I have a request for a particular gender or race of service provider. I selected the above-mentioned agency, considering my choices and preferences.**

 **□ Appointment Date is \_\_\_\_\_\_\_\_\_\_\_\_**

 **□ Consents signed to release information or provide treatment**

 **□ Provider Choice Form placed in client file**

Client was denied services for the following reason(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED**

**INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**General Information:**

Cosby Counseling & Consulting PLLC

**(980)522-8061 Office/Emergency/ 24/7/365 After-Hours**

**Urgent Services Available with 48 hours**

Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)\* and the Confidentiality Law\*\*. Under these laws the program may not say to a person outside of the program that you attend the program, nor may the program disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by the federal laws referenced in 42 CFR Part 2D, GS 122C 53-56 and stated below. Confidential information may not be released without written consent except in emergency or as provided for in 45 CFR 164 of HIPAA or in NC GS 122C 152-156.

The provision of services is contingent upon such consent and of the need for such release. The client or legally responsible person shall give consent voluntarily. The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operations. However, federal law permits the program to disclose information in the following circumstances without your written permission:

1.To program staff for the purposes of providing treatment and maintaining the clinical record;

2.Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, record storage services, billing services);

3.For research, audit or evaluations (e.g. State licensing review, accreditation, program data reporting as required by the State and/or Federal government);

4.To report a crime committed on the program’s premises or against program personnel;

5.To medical personnel in a medical/psychiatric emergency;

6.To appropriate authorities to report suspected child abuse or neglect;

7.To report certain infectious illnesses as required by state law;

8.As allowed by a court order.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: Revoking a consent to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with that organization. Such a violation may result in legal consequences for you.).

Record Keeping:

All clinical records are stored securely to ensure confidentiality. In the event that records are transported they are stored in a double locked area until such time they are returned to the office.

**Access to Records:**

Access to treatment records are limited to those individuals/ entities with a valid release of information on file signed by the patient or their legal guardian when applicable. Patients have access to their records and can review them with the clinician at their request.

**Off Site Therapeutic Services**

 If/When services are provided in an location other than the practice office the same practice and confidentiality standards apply.

**North Carolina Law**

Some North Carolina laws give you additional protection and rights over federal laws and we will follow them whenever they apply. A few examples of North Carolina law are:

North Carolina protects your discussions with a mental health provider about your mental health treatment. Any request by you for treatment and rehabilitation for drug dependence will be treated as confidential, even if we refer you to someone else. In general, you must consent before we disclose information about your mental health, developmental disabilities, or substance abuse services. However, we can disclose this information without your consent to help us care for you, for our health care operations, for your emergency care, and to others when necessary to coordinate your care. We are also allowed, and sometimes required, to disclose you information in the same situations which do not require your authorization. If we believe it is in your best interest, we may disclose your information to start a guardianship or involuntary commitment proceeding. We can disclose to your next of kin when you are admitted or discharged form a mental health, developmental disabilities, or substance abuse facility, if we believe it is in your best interest, but only if you do not object.

If you are a minor, you have the right to consent to certain treatments without consent of your parent or guardian: (1) for pregnancy, (2) for abuse of controlled substances or alcohol; and (3) emotional disturbance. North Carolina has certain requirements for parental or guardian consent for abortions.

**Your Rights**

• Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

• You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The program will accommodate such requests that are reasonable and will not request an explanation from you.

• Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

• Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program’s records, and to request and receive an accounting of disclosures of your health related information made by the program during the six (6) years prior to your request.

• If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.

• To make any of the above requests, you must fill out the appropriate form that will be provided by the program.

• You also have the right to receive a paper copy of this notice.

**Additional Rights**

•The right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation.

•To treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse.

•To live as normally as possible while receiving care and treatment.

•To be informed of the risks/benefits of any treatment recommendations.

To participate in any treatment decisions as it relates to your care.

•To refuse treatment.

•Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities.

•To have your privacy protected unless otherwise permitted by you or state and/or federal law.

•To request any information in your client record unless it is determined that such information would be detrimental to your care.

•To know about any fees and cost’s of care prior to initiation of any services offered by the provider.

•To know the qualifications and educational background of the person treating you.

•To be informed by the provider in advance of any decision to terminate the therapeutic relationship with you.

•To know that your treatment will be terminated if you commit a crime on the premises, when your welfare or the welfare of others are threatened by your continued participation in the program.

•To appropriate referral, if necessary, when you are discharged form the program.

•To be free from unwarranted invasion of privacy.

•To be protected from harm, abuse, and exploitation.

•To receive accommodations in accordance with the American Disabilities Act (ADA) and/or as required by law.

•To expect the provider to make a reasonable response to your requests.

•To file a complaint against the provider without retaliation from the provider.

•To contact the Disability Rights of North Carolina, the statewide agency designated under the federal and state law to protect and advocate for the rights of persons with disabilities. Their contact number is (877) 235-4210.

**The Use of Your Information at the program**

In order to provide you with the best care, the program will use your health and treatment information in the following ways:

• Communication among program staff (including students interns or volunteers) for the purposes of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning, and other treatment related processes.

• Communication with Business Associates such as clinical laboratories (blood work, urinalysis), food service (special dietary needs), agencies that provide on-site services (lectures, group therapy) long term record storage.

• Reporting data to the NC DHHS.

The Program’s Duties:

The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice. Please note that clinical records will not be released to third parties until the payment has been secured/ received for services rendered.

Complaints and Grievances:

Patients have the right to make a complaint about the Privacy of their Health Information to the following:

•Deanna Cosby, 980-522-8061.

•Disability Rights of North Carolina, 2626 Glenwood Avenue Suite 550, Raleigh, NC 27608. Voice (919) 856-2195 Toll Free Voice (877) 235-4210, TTY 888-268-5535. Fax: (877) 235-4210. Email: info@disabilityrightsnc.org.

•Office for Civil Rights. U.S. Department of Health & Human Services. Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909. Voice Phone (404) 562-7886. TDD (404) 331-2867. FAX (404) 562-7881.

You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

***Professional Disclosure***

**Please read the information that follows carefully because it will help you to use our services most effectively.**

**Professional Credentials**

Deanna Cosby is a licensed by the North Carolina Board of Licensed Professional Counselors and the North Carolina Board of Substance Abuse Practice & Prvention. Licensed Clinical Mental Health Counselors are governed by the NCLPCB (919-661-0820), and Licensed Clinical Addiction Specialists are governed by the NCSAPB (919-832-0975). Deanna Cosby adheres to strict ethical guidelines established by their professional licensing board.

**Services Offered and Theoretical Approach**

Deanna Cosby offers an array of services including psychotherapy, consultation, and clinical supervision. I provide a range of psychological services to children, adolescents, and adults, including individual, family, couples and group psychotherapy. I believe counseling is a collaborative effort in which we work together to assist you in changing the thoughts, feelings, and behaviors that are interfering with your being able to live a fulfilling life. I will not attempt to impose our values or beliefs on you. I may use variety evidenced based counseling methods based on theories grounded in Motivational Enhancement Theories, Behavioral Modification, Relapse Prevention, Supportive Expressive Therapy, and Cognitive Behavioral Theory.

**Visits and Fees**

Deanna Cosby is committed to providing the best treatment possible at a reasonable rate. Unless specified by the contract that we may have with your particular insurance company (i.e. Medicaid): the fee for an initial session is $110.00; treatment sessions (individual, family, and group) after the initial meeting are $70.00.

Normal office hours: Monday –Friday 9am -7pm, Saturday 10am-2pm, and by appointment only.

**Cancellations**

Please provide 24hrs notice if you will be unable to make your scheduled appointment.

**Contact**

You may contact Deanna Cosby by phone and I will make every effort to return your call within 24 hours for all clinical non-emergencies. If you feel that you cannot safely wait for us to return your call, you should follow the emergency plan as described below.

**Emergency Plan**

If a mental health emergency should arise, you are instructed to call your first responder (Deanna Cosby), 980-522-8061 24/7/365.

**AGREEMENT FOR BILLING**: I understand that Deanna Cosby/ Cosby Counseling & Consulting PLLC is direct-enrolled providers of Medicaid services. As such, Deanna Cosby will directly bill Medicaid for treatment services for those clients who have active Medicaid third party coverage. In such cases, Deanna Cosby agrees to accept Medicaid payment as payment in full for treatment services, and will not bill the client for such services.

**AGREEMENT TO PAY**: If the client or client’s legal guardian does not have third party coverage that agrees to pay the established fee for treatment by Deanna Cosby it becomes the client’s legal guardian’s responsibility to pay the treatment fee. If this is the case, I understand that: I may be denied an appointment and/or sent to a collection agency if I refuse to pay when I have I have the ability to pay, and it is my responsibility to inform Deanna Cosby of any changes which affect the billing of my account, and I may be charged for a scheduled appointment if not canceled twenty-four (24) hours in advance.

**ASSIGNMENT OF BENEFITS**: I authorize payment by the insurance company/third party payor and the legal guardian directly to Deanna Cosbyfor services rendered, and /or payment of benefits to be applied to the public subsidy balance because of a reduced ability to pay. I understand that I am financially responsible to Charlotte Counseling and Consulting for charges applied to the insurance deductible and for all charges limited by the insurance carrier. If unpaid balance is sent to a collection agency, I will be responsible for any legal fee and/or interest associated with collection of the debt.