Sherman Boone, LCSW

REFERRAL FORM

Date: _____

Client Name:_____ **Client MR#**:_____

DOB:_____ **AGE**:____ **Gender**:_____**SS#**_____

Medicaid ID#:_____ **Other Insurance:**_____

Client Address:_____

Parent/Guardian Name:_____**Phone#:**_____

Parent/Guardian Address:_____

Referral Source Name/Agency:_____

Referral Source Phone #:_____**Relationship to Child:**_____

AGENCIES OR PROFESSIONALS ALREADY INVOLVED:

Name:_____**Agency:**_____**Phone#:**_____

Name:_____**Agency:**_____**Phone#:**_____

****Presenting Problem: (include clinical justification for medical necessity for BHO services, i.e. suicidal/homicidal ideation, SA issues, current or past treatment/providers/ meds, behavioral problems, abuse or neglect issues, other symptoms. Please also include any diagnoses made by previous therapist or developed during intake/diagnostic assessment):**

_____

_____

_____

_____

_____

_____

_____

_____

Sherman Boone, LCSW

Consent for Treatment

Client's Name: _____Client's Record #: _____

I, _____, give my consent for, Sherman Boone, LCSW, to provide services for the above named client. I reserve the right to withdraw consent at any time. In addition, I reserve the right to refuse, at any time, any services offered without the threat or termination of services. I also grant permission to seek medical treatment from a hospital or physician in the case of a crisis or emergency event.

Signed: _____ ☐ - Client

Date: _____ ☐ - Parent

☐ - Other Legally Responsible Person

Witness: _____

Date: _____

Sherman Boone, LCSW

CONSUMER RIGHTS

1. The right to participate in the development of a written person-centered treatment plan that builds on individual needs, strengths and preferences. A treatment plan must be implemented within 15 days after services start.
2. The right to take part in the development and periodic review of your treatment plan and to consent to treatment goals in it. A copy of the service plan will be provided within 14 days after service plan is developed and /or reviewed. If service is not provided within above specified time, a formal request can be made for a copy of service plan, either by verbal request --in person or by phone, or written request by email or letter. Upon receipt of a formal request of service plan, the document will provided within 7 days.
3. The confidentiality of your care and treatment are protected by law. Except as allowed by law and agency regulations, your records and other information about you will not be released without your written permission. Circumstances under which we may be required to share information with another about the services you receive include: in event of emergency; at the request of the payer source; and in the event of audit or review
4. You have the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability.
5. Before you agree to your plan, you will be informed of the benefits or risk involved in the services you will receive. You have the right to consent to treatment and may withdraw your consent at any time. You have the right to refuse treatment as described in the statute without threat or termination of services except as outlined in the statute. If you have asked to receive services, you always have a right to agree to or refuse any specific treatment. The only time you can be treated without your consent is in an emergency situation, or when it has been court-ordered, or if you are a minor and your parents have given permission. A minor may seek and receive periodic services from a physician without parental consent for the prevention, diagnosis and treatment of (1) venereal disease and other diseases reportable under G.S. 130A-135, (2) pregnancy, (3) abuse of controlled substances or alcohol, and (4) emotional disturbance.
6. You have the right to be fully informed of all your rights and responsibilities as a client of the program.
7. You have the right to appropriate and professional care relating to your needs.
8. You have the right to be fully informed in advance about the care to be provided by the program.
9. You have the right to be fully informed in advance of any changes in the care that you may be receiving and to give informed consent to the provision of the amended care.
10. You have the right to participate in determining the care that you will receive and altering the nature of the care as your needs change.

11. The right to voice complaints or appeals about the organization or the care it provides.
12. The right to treatment in the most natural, age-appropriate and least
13. restrictive environment possible.
14. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
15. The right to request and receive a copy of your medical record, subject to therapeutic privilege, and to request that the medical record be amended or corrected. If the doctor or therapist determines that this would be detrimental to
16. your physical or mental well-being, you can request that the information be sent to a physician or professional of your choice.
17. If you disagree with what is written in your medical records, you have the right to write a statement to be placed in your file. However, the original notes will also stay in the record until the statute of limitations ends according to the MH/DD/SA retention schedule (11 years for adults, 12 years after a minor reaches the age of 18, 15 years for DUI records).
18. The right to a second opinion from a qualified health care professional within the network, or Alliance will arrange for the enrollee to obtain one outside of the network at no cost to the enrollee.
19. The right to ask questions when you do not understand your care or what you are expected to do.
20. The right to voice grievances about Alliance or the care you receive from providers in the Alliance Network.
21. The right to appeal any Alliance decision to deny, reduce, suspend or terminate a requested service.

22. The right to freedom of speech and freedom of religious expression.
23. The right to equal employment and educational opportunities.
24. The right to privacy and security of their protected health information. Alliance's
25. Notice of Privacy Practices is attached to this Manual as Appendix E.
26. Minors have the right to agree to some treatments without the consent of a parent or guardian:
27. For treatment of venereal diseases.
28. For pregnancy.
29. For abuse of controlled substances or alcohol.
30. For emotional disturbances.
31. If at any time a consumer needs information on his/her rights or believes that his/her rights have been violated, they may contact the Alliance Access and Information Center at (800) 510-9132 twenty-four hours a day/7 days a week/365 days a year.
32. If at any time or for any reason you feel that you cannot get the information you need, you have the right to contact:
33. Unless a person has been declared incompetent by a court of law, a consumer has the same basic civil rights as other citizens. Civil rights include the right to marry and divorce, to sue others in court, to have and raise children, to sign contracts, the right to vote, and the right to sell, buy and own property. Persons determined to be incompetent and that are assigned a court-appointed guardian retain all legal and civil rights except those rights that are granted to the guardian by the court. For example, many incompetent persons retain the right to vote.
34. Consumers of mental health, substance abuse and developmental disability services have the following rights: The right to receive information about Alliance, its services, its providers, and member rights and responsibilities presented in a understandable manner.
35. The right to be treated with respect and recognition of your dignity and your right to privacy.
36. The right to a candid discussion with providers on appropriate or medically- necessary treatment options for your conditions, regardless of cost or benefit coverage. (You may need to decide among relevant treatment options, taking into account the risks, benefits and consequences, including your right to refuse treatment and to express your preferences about future treatment decisions regardless of benefit coverage limitation.)
37. You have the right to voice grievances with respect to care that is provided and to expect that there will be no reprisal for the grievance expressed.
38. You have the right to expect that the information you share with the agency will be respected and held in the strict confidence, to be shared only with your written consent and as it relates to the obtaining of other needs community services.
39. You have the right to except the preservation of your privacy and respect for your property.
40. You have the right to receive a timely response to your request for service.
41. Please be aware that services will be terminated, discharge effective immediately upon 3 consecutive missed sessions, without a formal written medical explanation.

42. Session will be immediately terminated, and rescheduled, if the consumer/client attempts to participate in session while impaired (drugs and/or alcohol).
43. Alliance Behavioral Healthcare ("Alliance") 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. If you have questions about any part of this Notice or if you want more information about the privacy practices at Alliance Behavioral Healthcare, please contact the Privacy Officer at (800) 510-9132 or at 4600 Emperor Boulevard, Durham, NC 27703.
44. https://www.alliancebhc.org/consumers-families/...rights/notice-of-privacy-practices/

45. If at any time or for any reason you feel that you cannot get the information you need, you have the right to contact:

    - Disability Rights North Carolina
    - Toll Free: (877) 237-4210
    - Website: www.disabilityrightssnc.org

    - The N.C. Mental Health Consumers' Organization Inc.
    - 1-800-326-3842

    - The N.C. Careline
    - 1-800-662-7030

Each of these offices is open Monday-Friday, between 8:00 a.m. and 5:00p.m.

_____ _____ _____ _____

Consumer Printed Name Date

_____ __ _____

Consumer Signature Date

Sherman Boone, LCSW

CONSENT FOR THE RELEASE OF INFORMATION

I, _____, authorize

_____
(Name or general designation of person and agency making disclosure)

To Disclose to:

_____
(Name of person or organization to which disclosure is to be made)

The following information:

_____

_____
(Nature of the information)

The purpose of the disclosure authorized herein is to:

_____

_____
(Purpose of disclose, as specific as possible)

I understand that my records or personal information cannot be disclosed without my prior written consent. By signing this release, I understand that the information disclosed is professional and confidential, and may be communicated in written and/or oral form. Please also note you have the right to opt out releasing any information pertaining to HIV/AID and substance abuse**. If opting out, please initial on the appropriate line below.**

___ I do not wish for any substance abuse related information to be released.

___ I do not wish for any HIV/AID related information to be released.

Consent is also subject to revocation at anytime except to the extent of actions already taken. I also understand that I may revoke this consent at any time in writing, and that in any event, this consent expires automatically as follows:

_____
(Specification of the date*, event, or condition upon which the consent expires)

*Expiration date should not exceed one year from the date of initial consent

_____ _____
(Signature of client or guardian) (Date)

_____ _____
(Signature of witness) (Date