

CLIENT RIGHTS CONSENT

Client's Legal Name _____

DOB: _____

Client Record # _____

_____ (Initial here once informed) **Restrictive Interventions Firm Foundation DO Not Authorize the Use of Restrictive interventions**

I give permission to the above-mentioned agency to perform restrictive intervention on when all other methods have been exhausted when trying to deescalate the above-mentioned consumer. Following the utilization of a restrictive intervention, staff shall conduct debriefing and planning to eliminate or reduce the probability of the future use of restrictive interventions. I understand that this consent is only valid for unplanned restrictive interventions and is not invalid unless the client or legally responsible person chooses to withdraw the consent.

_____ (Initial here once informed) **Suspension and Expulsion from Service**

I understand that if I do not comply with the rules outlined by the agency and become a possible threat to others served within this agency he/she may possibly be suspended or expelled from services. I understand that this would be the agency's last result before assessing the client to see if he/she meets the criteria to discharge. However, if it results in discharge the agency will follow its due process procedure before exhausting all other means.

_____ (Initial here once informed) **Search and Seizure**

I understand that each client shall be free from unwarranted invasion of privacy. However, I understand that searches of my child's living area may occur. I also give permission to the agency to perform random planned or unplanned searches and seizures on my child's belongings, or property in his/her possession. I understand that each search will be documented to include; scope of search, reason for search, procedures followed in the search, description of any property found and an account of the disposition of seized property.

_____ (Initial here once informed) **Carolina Legal Assistance**

I understand a written summary of client rights shall be made available to each client and legally responsible person. I have been informed of his/her right to contact The Carolina Legal Assistance who assumed the role of the (GACPD) , the statewide agency designated under federal and state law to protect and advocate the rights of persons with disabilities.

_____ (Initial here once informed) **Admissions into Services Agreement**

I understand that I shall be informed of services rendered by this agency upon admission or entry into services.

_____ (Initial here once informed) **Agency Rules**

I understand the rules that I am/my child is expected to follow and possible penalties for violation of the rules.

_____ (Initial here once informed) **Consent regarding Disclosure of Confidential Information**

I understand that the agency will follow its policy as it relates to protecting my rights regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56.

_____ (Initial here once informed) **Consent regarding Treatment**

I give permission to **Firm Foundation, Inc.** to obtain a copy of my/my child's treatment / Habilitation plan and/or other information that relates to him/her in order for the agency to adequately serve.

_____ (Initial here once informed) **Fee Assessment**

I understand that I will be responsible for fees assessed by my child that Medicaid does not cover as it relates to the treatment of my child. I understand that the agency will do everything possible to avoid collection from me/my child on behalf of treatment/habilitation services rendered.

_____ (Initial here once informed) **Grievance Procedure**

Client's Legal Name _____

DOB: _____

Client Record # _____

I understand that I/my child has the right to disclose any grievances that he/she may have as it relates to the agency. I understand that **Firm Foundation, Inc.** will be provided a description of the assistance that the agency will be provided. I understand that the agency will be provided the results of any grievance submitted on behalf of my/my child. I understand that he/she will be given a chance to dispute the results of his/her grievance if the findings are not to his/her satisfaction. I understand that I can contact Carolina Legal Assistance who replaced (GACPD)/or the Local Mental Health LME.

_____ (Initial here once informed) **Informed of Client Rights**

I understand and have been informed of and received a copy of the Client Rights handbook, which includes information on Client's Rights, HIPPA, and Privacy and Confidentiality. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent. I have received, and have been explained my Rights to Privacy. **Firm Foundation, Inc.** gave me a copy of the Client Rights handbook and I understand these rights, which are designed to protect the privacy of me/ and/or my child.

_____ (Initial here once informed) **Social Integration**

I give **Firm Foundation, Inc.** my permission to allow my child to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. My child shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62 (e).

_____ (Initial here once informed) **Emergency Medical Treatment**

I give **Firm Foundation, Inc.** my permission to seek emergency care for my child from a hospital or physician. I also give **Firm Foundation, Inc.** the consent to seek and sign consent for preventive and emergency medical care for my child in my absence. It is understood that **Firm Foundation, Inc.** will attempt to contact me, or another designated responsible adult as soon as possible in the event of an emergency.

_____ (Initial here once informed) **Disaster and Risk Management Plan**

I have been informed and received a copy **Firm Foundation, Inc.** Disaster Preparedness Plan and Risk Management Practices. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent.

_____ (Initial here once informed) **Financial Release**

I have been informed and received a copy **Firm Foundation, Inc.** may use confidential information about me to bill and be paid for services. I hereby consent **Firm Foundation, Inc.** to release information to NC TRACKS (the State of NC managed care vendor) and/or the referring Area Program.

_____ (Initial here once informed) **Transport**

I have been informed and received a copy **Firm Foundation, Inc.** to provide transportation to my child, and agree to hold **Firm Foundation, Inc.** harmless for any accident/injury that results from the provision of transportation.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

Signature of Client or Legal Guardian

Date

Signature of Agency Representative

Date

Federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C)

EMERGENCY CONTACT FORM

I _____ (Client or if Minor Legal Guardian), give Firm Foundation, Inc. and the providers of Firm Foundation, permission to access the following contacts in case of emergency and to provide medical attention necessary to myself/child.

Client Name: _____ DOB: _____

EMERGENCY CONTACT PERSON

1st Emergency Name: _____ Relationship: _____

Work or Cell Phone Number: _____

Address (Street, City, State, & Zip): _____

EMERGENCY CONTACT PERSON

2nd Emergency Name: _____ Relationship: _____

Work or Cell Phone Number: _____

Address (Street, City, State, & Zip): _____

PREFERRED LICENSED MEDICAL PROVIDER

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____

Notice Regarding Potential Emergencies:

Routine Medical & Dental Treatment:

I hereby give permission to the staff of Firm Foundation, Inc. to seek routine medical and dental treatment on behalf of the above-named client.

Emergency Medical Treatment:

In case of sudden illness/accident/emergency, I hereby give permission to the staff of Firm Foundation, Inc. to seek emergency treatment on behalf of the above-named client should the need arise. It is understood that a licensed medical provider and/or hospital emergency room personnel will provide this treatment. In addition, a copy of current medications, known medical conditions and allergies may be released. Efforts will be made to contact a person named below prior to treatment, should this be possible.

The above consent has been read by me or to me and explained to me by an employee of Firm Foundation, Inc. to seek. I agree with the above consents as evidenced by the signature below.

Client Signature (If Minor Legal Guardian)

Relationship

Date

Firm Foundation Clinician/Authorized Representative Signature

Date

PERMISSION FOR ADMINISTERING NON-PRESCRIPTION MEDICATION

As the physician/parent/guardian/custodian of _____ I agree to allow the staff and foster parents of (Firm Foundation, Inc.) to administer the following non-prescription medications only as needed for periodic treatment of condition as described below:

(Signature of physician is required if the client is currently taking prescription medication)

EXTERNAL

Medication

For Treatment of

- 1. Neosporin or antibiotic ointment
- 2. Calamine lotion (with or without Phenol)
- 3. Rubbing alcohol
- 4. Betadine scrubs or soap and water

- Minor burns, cuts, abrasions
- Allergic rashes (poison ivy, poison oak, etc.)
- Insect bites
- Cleaning area of minor injury

INTERNAL

- 1. Acetaminophen tablets (Tylenol, Datril,
- 2. Pepto Bismol liquid
- 3. Kaopectate liquid
- 4. Chlortumeton tablets Chlorpheninamine (antihistamine)
- 5. Dextromethorphan (lozenge and spray form)
- 6. Cepacol or chloraseptic lozenge
- 7. Mineral oil
- 8. Milk of Magnesia
- 9. Benadryl capsules
- 10. Ipecac syrup

- Headaches or minor pain (Panadol, etc.)
- Upset stomach
- Diarrhea
- Common cold or minor allergic reaction to insect bites
- Cough
- Sore throat
- Constipation
- Constipation
- Allergic reaction (bee stings)
- Induce vomiting (**clear with doctor and/or emergency room Before administering**)

Please X out above if your child has a known allergy to any of these medications or you have an objection to the administration of any of these medications.

Signature of Physician
(Signature of Physician is required if client is currently taking prescription medication)

Date

Signature of Parent, Guardian, or Custodian

Date

Non-prescription medicines are to be administered according to package directions and only for symptoms listed on the package labeling. If symptoms persist, the client physician will be consulted.

VISITATION and CONTACT PLAN

For each child, state type, time, level of supervision, frequency, duration, location of visits, and transportation arrangements. Revise as often as necessary. If children are separated, also include a plan for sibling visitation. Different forms should be completed when the children have different visitation plans.

Child(ren) Name(s):			
This plan is effective through date:			
Supervision Required:	<input type="checkbox"/>	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
No By Whom:			
Place of visit:			
Frequency of visits:			
Hours:			
Length of visits:			
Transportation Arrangements:			
Special Considerations:			
Phone Calls Allowed:	<input type="checkbox"/>	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
With Whom:	Monitoring Needed:	<input type="checkbox"/>	Yes
		<input type="checkbox"/>	No
	Monitoring Needed:	<input type="checkbox"/>	Yes
		<input type="checkbox"/>	No
Mail/Email Allowed:	<input type="checkbox"/>	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
From Whom:	Monitoring Needed:	<input type="checkbox"/>	Yes
		<input type="checkbox"/>	No
	Monitoring Needed:	<input type="checkbox"/>	Yes
		<input type="checkbox"/>	No
Send All Mail/Email to:			

Signatures:
 Child/Youth (if appropriate): _____
 Parent(s): _____
 Social Worker: _____
 Others: _____

Date: _____
 Date: _____
 Date: _____
 Date: _____

VIDEOTAPE / PHOTOGRAPH / RESEARCH CONSENT FORM

I hereby authorize Firm Foundation, Inc. to MAKE and USE the following of _____
(Client's name)

Check all boxes you authorize consent to.

Audio-Visual recordings

Photograph of my image

The agency will use these recordings for the purpose of identification, promotional and public awareness.

I understand that this authorization will be time-limited until discharge from the program and that I have the right to change or revoke this consent at any time.

OR

I decline authorization of audio-visual recordings and/or photographic imaging of

(Client's name)

initial here

I hereby authorize _____ to participate in research being conducted on behalf of Firm Foundation, Inc.
(Client's name)

I understand that this authorization will be time-limited until discharge from the program and that I have the right to change or revoke this consent at any time.

OR

I decline authorization for _____ to participate in research being conducted on behalf of Firm Foundation, Inc.
(Client's name)

Client signature (required if age 12 or older)

Date

Parent, guardian or legal custodian signature

Date

Consent to Release Personal and Medical Information

I, _____ hereby request and authorize
(Client Name or Legal Guardian if Minor)

Firm Foundation, Inc. to use or disclose my protected health information to the following:

Mental Health Provider: _____
Client Name (Print): _____ DOB: _____

Information released may be verbal, electronic, or written and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (Please initial beside each applicable document)

- | | |
|---|---|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Discharge Summaries <input type="checkbox"/> |
| <input type="checkbox"/> Treatment Plans | Aftercare Plans/Orders <input type="checkbox"/> |
| <input type="checkbox"/> Treatment Recommendations <input type="checkbox"/> | Alcohol/Drug Treatment <input type="checkbox"/> |
| Psychiatric Evaluations <input type="checkbox"/> | Clinical Assessments <input type="checkbox"/> |
| Psychological Evaluations <input type="checkbox"/> | IEP/School Records <input type="checkbox"/> |
| Progress/Psychotherapy Notes | Other: |

I understand the purpose of the disclosure/redisclosure will be used for: Mental Health Treatment

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipients of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

This consent will expire on _____ not more than 365 days from the date of signature.

When this authorization is requested from the client, a copy of this signed release form shall be provided to the client or legally responsible person. The client authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C 53(c).

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, Firm Foundation, Inc. I understand that I may refuse to sign this release of information form. I understand that Firm Foundation, Inc., may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form. I understand that Firm Foundation, Inc., may charge a reasonable fee for copies of my medical records.

Client Signature (Legal Guardian if Minor) Relationship Date

Clinician/Authorized Representative Signature Date

Consent to Release Personal and Medical Information

I, _____ hereby request and authorize
(Client Name or Legal Guardian if Minor)

Firm Foundation, Inc. to use or disclose my protected health information to the following:

Foster Parent: _____

Client Name (Print): _____ **DOB:** _____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: *(Please initial beside each applicable document)*

- | | |
|---|---|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Alcohol/Drug Treatment |
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Clinical Assessments |
| <input type="checkbox"/> Treatment Recommendations | <input type="checkbox"/> IEP/School Records |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Psychological Evaluations | |
| <input type="checkbox"/> Progress/Psychotherapy Notes | |
| <input type="checkbox"/> Discharge Summaries | |

Purpose of use or disclosure: *(Please initial beside each applicable document)*

- | | |
|--|--|
| <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Coordination of Service |
| <input type="checkbox"/> Court Proceedings | <input type="checkbox"/> Determination of Benefits |

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Client Signature (Legal Guardian if Minor)	Relationship	Date
--	--------------	------

Clinician/Authorized Representative Signature	Date
---	------

Consent to Release Personal and Medical Information

I, _____ hereby request and authorize
(Client Name or Legal Guardian if Minor)

Firm Foundation, Inc. to use or disclose my protected health information to the following:

School: _____

Client Name (Print): _____ **DOB:** _____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (*Please initial beside each applicable document*)

- | | |
|---|--|
| <input type="checkbox"/> School Records (attendance, grades Suspension) | <input type="checkbox"/> Psychological Evaluations |
| <input type="checkbox"/> IEP/BIP | <input type="checkbox"/> Clinical Assessments |
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Treatment Recommendations |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Medications | |

Purpose of use or disclosure: (*Please initial beside each applicable document*)

- | | |
|--|--|
| <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Coordination of Service |
| <input type="checkbox"/> Court Proceedings | <input type="checkbox"/> Determination of Benefits |

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Client Signature (Legal Guardian if Minor)

Relationship

Date

Clinician/Authorized Representative Signature

Date

Consent to Release Personal and Medical Information

I, _____ hereby request and authorize
(Client Name or Legal Guardian if Minor)

Firm Foundation, Inc. to use or disclose my protected health information to the following:

Other: _____

Client Name (Print): _____ **DOB:** _____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (*Please initial beside each applicable document*)

- | | |
|--|---|
| <input type="checkbox"/> Medications/Prescriptions | <input type="checkbox"/> Progress/Psychotherapy Notes |
| <input type="checkbox"/> Medical Examination/Records | <input type="checkbox"/> Discharge Summaries |
| <input type="checkbox"/> Dental Examination/Records | <input type="checkbox"/> Alcohol/Drug Treatment |
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Clinical Assessments |
| <input type="checkbox"/> Treatment Recommendations | <input type="checkbox"/> IEP/School Records |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Other: _____ |

Purpose of use or disclosure:

(*Please initial beside each applicable document*)

- | | |
|--|--|
| <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Coordination of Service |
| <input type="checkbox"/> Court Proceedings | <input type="checkbox"/> Determination of Benefits |

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Client Signature (Legal Guardian if Minor)

Relationship

Date

Clinician/Authorized Representative Signature

Date

Consent to Release Personal and Medical Information

I, _____ hereby request and authorize
(Client Name or Legal Guardian if Minor)

Firm Foundation, Inc. to use or disclose my protected health information to the following:

Medical Provider: _____

Client Name (Print): _____ **DOB:** _____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: *(Please initial beside each applicable document)*

- | | |
|--|---|
| <input type="checkbox"/> Medications/Prescriptions | <input type="checkbox"/> Progress/Psychotherapy Notes |
| <input type="checkbox"/> Medical Examination/Records | <input type="checkbox"/> Discharge Summaries |
| <input type="checkbox"/> Dental Examination/Records | <input type="checkbox"/> Alcohol/Drug Treatment |
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Clinical Assessments |
| <input type="checkbox"/> Treatment Recommendations | <input type="checkbox"/> IEP/School Records |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Other: _____ |

Purpose of use or disclosure:
(Please initial beside each applicable document)

- | | |
|--|--|
| <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Coordination of Service |
| <input type="checkbox"/> Court Proceedings | <input type="checkbox"/> Determination of Benefits |

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Client Signature (Legal Guardian if Minor)

Relationship

Date

Clinician/Authorized Representative Signature

Date

Consent to Release Personal and Medical Information

I, _____ hereby request and authorize
(Client Name or Legal Guardian if Minor)

Firm Foundation, Inc. to use or disclose my protected health information to the following:

Dental Provider: _____ **Client**

Name (Print): _____ **DOB:** _____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (*Please initial beside each applicable document*)

- | | |
|--|---|
| <input type="checkbox"/> Medications/Prescriptions | <input type="checkbox"/> Progress/Psychotherapy Notes |
| <input type="checkbox"/> Medical Examination/Records | <input type="checkbox"/> Discharge Summaries |
| <input type="checkbox"/> Dental Examination/Records | <input type="checkbox"/> Alcohol/Drug Treatment |
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Clinical Assessments |
| <input type="checkbox"/> Treatment Recommendations | <input type="checkbox"/> IEP/School Records |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Other: _____ |

Purpose of use or disclosure: (*Please initial beside each applicable document*)

- | | |
|--|--|
| <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Coordination of Service |
| <input type="checkbox"/> Court Proceedings | <input type="checkbox"/> Determination of Benefits |

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This consent will expire on _____ not more than 365 days from the date of signature.

When this authorization is requested from the client, a copy of this signed release form shall be provided to the client or legally responsible person. The client authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C 53(c).

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, Firm Foundation, Inc. I understand that I may refuse to sign this release of information form. I understand that Firm Foundation, Inc., may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form. I understand that Firm Foundation, Inc., may charge a reasonable fee for copies of my medical records.

Client Signature (Legal Guardian if Minor) Relationship

Date

Clinician/Authorized Representative Signature

Date