ABC of NC

New Client Intake

Client Information

Last Name:		First Name:		Middle Name:
Date of Birth:	Sex/Gender:	Preferred Name:		
Race/Ethnicity:		Child lives with:		Primary Language:
Street Address:				
City:		State:	Zip:	County:
Diagnosis(es):		Date of ASD diagnosis:		ASD diagnosis given by:

Parent/Guardian (A) Information

Last Name:		First Name:		Middle Name:
Date of Birth:	Sex/Gender:	Race/Ethnicity:		Preferred Name:
Relationship to Client:		If legal guardian, indicate relationship to client:		
Street Address:				
City:		State:	Zip:	County:
Email Address:				Primary Language:
Home Phone:		Cell Phone:		Business Phone:

Parent/Guardian (B) Information

Last Name:		First Name:		Middle Name:
Date of Birth:	Sex/Gender:	Race/Ethnicity:		Preferred Name:
Relationship to Client:		If legal guardian, indicate relationship to client:		
Street Address:				
City:		State:	Zip:	County:
Email Address:				Primary Language:
Home Phone:		Cell Phone:		Business Phone:

Person Financially Responsible (Guarantor)

Is person financially responsible same as Guardian A or Guardian B? If yes, then skip to next section.			Yes No
Person Responsible for Account:			Relationship to client:
Street Address:			
City:	State:	Zip:	County:
Date of Birth:	Sex: Male Female		Power of Attorney:
Employer:			Work Phone:

Insurance Information

Effective Date:		ID#:
Name of Insurance Company:		Group #:
Name of Insured (subscriber):		Client's relationship to subscriber:
Subscriber's Street Address:		
City:	State:	Zip:
Cell Phone #:	Date of Birth:	Social Security #:
Name of Employer:		Work Phone #:
Do you have additional insurance? YES NO If yes, we will need a copy of the card.		

Authorization for the Release of Medical Information and Assignment of Benefits

I authorize the release of my medical record from The ABC of NC Child Development Center in order to process any claims. I hereby authorize payment directly to ABC of NC Child Development Center for mental health benefits entitled under my insurance plans. I understand that as the client (or the client's parent/guardian) I am responsible for full payment. I understand fees for visits or evaluation services are payable at the time of service unless covered by insurance or arrangements have been made in advance. Fees for psychological test administration, interpretation, and write-up are also payable in advance.

____ __________________

Client Date of birth

____ __________________

Signature of Client of Legally Responsible Person Date

____ __________________

Witness Date

Significant Events

Have any of the following stressful events happened within the past 12 months? Place an "X" where appropriate.

	Parents Divorced or separated		Family accident or illness
	Death in the Family		Death of family pet
	Parent changes job or loses job		Change in child care arrangements
	Change in schools		Family Moved
	Family financial problems		Other:

Please describe the most upsetting event that has occurred to your child within the last 12 months:

____

____

Family History

Notate if any family member has had any of the following disorders on the left side of the form by placing an "X" in the appropriate column on the right.

	Self	Mother	Father	Brother	Sister	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Parental Grandpa
Problems with aggressiveness, defiance, and oppositional behavior as a child									
Problems with attention, activity, and impulse control as a child									
Learning Disabilities									
Speech Problems									
Failed to graduate high school									
Intellectual Disability									
Psychosis or Schizophrenia									
Depression for more than 2 weeks									
Anxiety Disorder									
Tics or Tourette's									
Alcohol Abuse									
Substance Abuse									
Arrests									
Physical Abuse									
Sexual Abuse									
Other Mental Illness:									

Client's Developmental and Medical Information

Pregnancy and Delivery

Length of Pregnancy (e.g. full term, 40 weeks, 32 weeks, etc.)	Length of delivery (number of hours from initial labor pains to birth):
Mother's age when child was born:	Child's birth weight:

Did any of the following conditions occur during pregnancy/delivery?

Bleeding	NO	YES	
Excessive weight gain (more than 30 lbs)	NO	YES	
Toxemia/ preeclampsia	NO	YES	
RH factor incompatibility	NO	YES	
Frequent nausea or vomiting	NO	YES	
Serious injury illness or injury	NO	YES	
Took prescription medications	NO	YES	If yes, name of medication:
Took illegal drugs	NO	YES	
Used alcoholic beverages	NO	YES	If yes, approximate number of drinks per week:
Smoked cigarettes	NO	YES	If yes, approximate number of cigarettes per day (e.g. ½ pack):
Was given medication to ease labor pains	NO	YES	If yes, name of medication:
Delivery was induced	NO	YES	
Forceps were used during delivery	NO	YES	
Had a breech delivery	NO	YES	
Had a cesarean section delivery	NO	YES	
Other problems:	NO	YES	Please describe:

Infancy

During the first 12 months, was your child:

Difficult to feed	NO	YES	Comments:
Difficult to get to sleep	NO	YES	Comments:
Colicky	NO	YES	Comments:
Difficult to put on a schedule	NO	YES	Comments:
Alert	NO	YES	Comments:
Cheerful	NO	YES	Comments:
Affectionate	NO	YES	Comments:
Sociable	NO	YES	Comments:
Easy to comfort	NO	YES	Comments:
Difficult to keep busy	NO	YES	Comments:
Overactive, in constant motion	NO	YES	Comments:
Very stubborn, challenging	NO	YES	Comments:

Are there any ethnic, cultural, and/or religious traditions, beliefs, or values of which you would like us to be aware? Yes No If yes, please explain:
Is there any family responsibility structure of which you would like us to be aware? (e.g. financial decision making, disciplinary decision making, etc.) Yes No If yes, please explain:

Health History

At any time has your child had any of the following:

Asthma	NEVER	PAST	PRESENT
Allergies	NEVER	PAST	PRESENT
Diabetes, Arthritis, or other chronic illness	NEVER	PAST	PRESENT
Epilepsy or seizure disorder	NEVER	PAST	PRESENT
Febrile seizures	NEVER	PAST	PRESENT
Chicken pox	NEVER	PAST	PRESENT
Heart or blood pressure problems	NEVER	PAST	PRESENT
High fevers (over 103)	NEVER	PAST	PRESENT
Broken bones	NEVER	PAST	PRESENT
Severe cuts requiring stitches	NEVER	PAST	PRESENT
Lead poisoning	NEVER	PAST	PRESENT
Head injury with loss of consciousness	NEVER	PAST	PRESENT
Surgery	NEVER	PAST	PRESENT
Lengthy hospitalization	NEVER	PAST	PRESENT

Speech or language problems	NEVER	PAST	PRESENT
Chronic ear infections	NEVER	PAST	PRESENT
Hearing difficulties	NEVER	PAST	PRESENT
Eye or vision problems	NEVER	PAST	PRESENT

Client's allergies including food, medication, environmental, etc. and/or any dietary restrictions:

Allergen/Restricted Item(s)	Effect(s)/Reaction(s)

Client's hospitalizations or serious/recurring illness(es) or injury(ies):

Dates	Age	Hospital	Describe

Client's past or current health/medical services:

Treatment Type	Date(s) Started/ Discontinued	Effect(s)	Physician

Client's past or current biomedical autism treatment(s):

Treatment Type	Date(s) Started/ Discontinued	Effect(s)	Physician

Client's past or current supplemental specialized services (e.g., speech language therapy, occupational therapy, etc.):

Treatment Type	Date(s) Started/ Discontinued	Effect(s)	Physician

Client's current daycare/school placement:

Name of Daycare/School:	Dates of Enrollment:	Grade(s):	Placement (e.g typical, autism, resource, gifted, etc.):
Have you ever been contacted by this daycare or school concerning any behavioral or developmental concerns? Yes No		If yes, explain:	
Teacher's Name:		Teacher's Email:	
Principal's Name:		School Phone #:	

Current Behaviors

Within the last 6 months, have you seen your child:

Communication/Language			
Babble	NO	YES	
Cries to communicate wants/needs	NO	YES	
Engages in self-injurious behavior (e.g. head banging, hand biting, etc.) to communicate wants/needs	NO	YES	
Engages in aggressive behavior (e.g. hits, pinches, bites others, etc.) to communicate wants/needs	NO	YES	
Engages in destructive behavior (e.g hits/throws objects, tips furniture, etc.) to communicate wants/needs	NO	YES	
Pulls others to communicate wants/needs	NO	YES	
Looks at others to communicate wants/needs	NO	YES	
Points to communicate wants/needs	NO	YES	
Uses sign language	NO	YES	

Uses an augmentative communication device	NO	YES	
Makes 1-word requests	NO	YES	
Makes 2-3-word requests	NO	YES	
Makes full sentence requests	NO	YES	
Asks questions (e.g. where, who, etc.)	NO	YES	
Answers questions	NO	YES	
Conversational with adults	NO	YES	
Conversational with peers	NO	YES	
Repeats words over and over	NO	YES	
Speaks well but slow to develop language	NO	YES	
Speech difficulties (i.e. difficult to understand)	NO	YES	
Did talk, but does not anymore	NO	YES	
Follows simple instructions (e.g. come here, etc.)	NO	YES	
Follows complex instructions (e.g. get dressed, etc.)	NO	YES	
Play/Social			
Interacts with toys in a repetitive or unusual manner	NO	YES	
Plays with electronic toys as designed	NO	YES	
Plays with non-electronic cause/effect toys (e.g. pound-a-ball, etc.) as designed	NO	YES	
Plays with manipulative toys (e.g. puzzles, blocks, etc.) as designed	NO	YES	
Engages in simple pretend play (e.g. feeds baby, etc.)	NO	YES	
Engages in elaborate pretend play (e.g. dollhouse scenarios, etc.)	NO	YES	
Plays with board/box games (e.g. Mousetrap, etc.) as designed	NO	YES	
Plays computer games as designed	NO	YES	
Independently entertains self in play for up to 5 minutes	NO	YES	
Readily explores new toys and activities	NO	YES	
Usually plays alone	NO	YES	
Joins others in play	NO	YES	
Appropriately interacts with parent(s)/guardian(s)	NO	YES	
Appropriately interacts with sibling(s)	NO	YES	

Appropriately interacts with peers	NO	YES	
Difficulty sharing toys/waiting for a turn	NO	YES	
Appropriately interacts with teachers	NO	YES	
Appropriately interacts with other adults	NO	YES	
Avoids eye contact	NO	YES	
Avoids social interaction (e.g. turns away from others, etc.)	NO	YES	
Encounters peer rejection	NO	YES	
Makes negative comments to others	NO	YES	
Teases others?	NO	YES	
In competitive situations, overreacts when losing	NO	YES	
Physical/Adaptive			
Displays stereotypic behavior(s) (e.g. hand flapping, body tensing, etc.)	NO	YES	
Poor motor coordination	NO	YES	
Lethargic/low energy	NO	YES	
Hyper/overly energetic	NO	YES	
Excessively noisy (e.g. yells, etc.)	NO	YES	
Fleeting attention span	NO	YES	
Requires constant attention	NO	YES	
Often has physical complaints (e.g. headaches, stomachaches)	NO	YES	
Has difficulty staying awake	NO	YES	
Has difficulty falling asleep	NO	YES	
Has difficulty staying asleep	NO	YES	
Takes naps regularly	NO	YES	
Has frequent nightmares	NO	YES	
Has a self-limited diet (due to food refusal)	NO	YES	
Feeds self finger foods	NO	YES	
Feeds self with utensils	NO	YES	
Disruptive at meal times	NO	YES	
Toilet trained on a schedule	NO	YES	
Initiates toileting	NO	YES	
Cries, whines, or pouts frequently	NO	YES	
Irritable	NO	YES	
Tantrums frequently	NO	YES	
Engages in self-injurious behavior (e.g. head banging, hand biting, etc.)	NO	YES	
Engages in aggressive behavior (e.g. hits, pinches, bites others, etc.)	NO	YES	

Engages in destructive behavior (e.g hits/throws objects, tips furniture, etc.)	NO	YES	
Difficulty responding to changes in routine	NO	YES	
Difficulty separating from parents/caregivers	NO	YES	
Unreasonable/excessive fears	NO	YES	
Recognizes dangerous situations	NO	YES	
Runs away/dashes from caregivers in the community	NO	YES	
Has run away from home	NO	YES	
Wanders off	NO	YES	
Difficulty with disciplinary control (e.g. reprimands are ineffective, etc.)	NO	YES	
Talks back to parent(s), guardian(s), or/other authority figures	NO	YES	
Academic			
Academically performs at grade level in math	NO	YES	
Academically performs at grade level in reading	NO	YES	
Academically performs at grade level in writing	NO	YES	

Additional Pertinent Information

List your child's favorite(s)- toys, activities, foods, characters, etc.

List your child's dislikes.

Item/Activity/Other	**His/Her Reaction(s)**

What are the client's strengths?
What behavior(s) and skill deficit(s) concern you most?
What do you want for the child's future?

Is there any other information you could provide that would help ABC of NC staff prepare for serving the client/family?

Application is valid only if a signed and dated "Service(s) Request" form indicating the service(s) requested is attached.

____ ________________________________

Parent/Guardian Signature Date

ABC of NC

First Aid Treatment Consent

I hereby give permission for my child, _______________________________, to receive first aid during program hours using supplies from a basic first aid kit.

Please list any allergies your child has to basic first aid items:

____

____

____

I understand that it is the responsibility of the parent/guardian to maintain communication with the staff regarding any changes in the client's condition, medication, and other health needs at the center. I do hereby release ABC of NC staff from any and all damages for injuries or illness occurring from the administration of traditional first aid. To the best of my knowledge, all of the above information is accurate and complete. I hereby authorize ABC of NC to share this information with staff as necessary for the safety and welfare of my child. Any consent granted is effective from the date of the signature until the parent/ guardian provides written notice of revocation.

____ ___________________

Parent/Guardian Signature Date

ABC of NC

Emergency Contact/Medical History/Treatment Release

Emergency Contact Information:

Client's Last Name:	Client's First Name:	Client's Middle Name:

Parent/Guardian A:

Last Name:	First Name:	Middle Name:
Cell Phone #:	Home Phone #:	Work Phone #:

Parent/Guardian B:

Last Name:	First Name:	Middle Name:
Cell Phone #:	Home Phone #:	Work Phone #:

Alternate Emergency Contact:

Last Name:	First Name:	Middle Name:
Cell Phone #:	Home Phone #:	Work Phone #:

ABC of NC

Medication Administration Policy

ABC of NC discourages the use and administration of medication at our center but realizes it may be sometimes necessary for the health of the client. All medications and medical procedures which may be taken or given outside program hours without adversely affecting the health of the client should not be administered at the center during program hours. Reasonable efforts should be made by the parent/guardian to obtain permission from the child's health care provider to adjust the dosages of prescribed medication so such may be provided at home before and/or after program hours.

ABC of NC authorizes staff to administer prescription medications, over the counter medications, and dietary supplements, upon receipt of the written authorization of the health care provider and the written authorization of the client's parent/guardian(s).

Prescription medication shall be placed in a prescription container indicating the child's name, the name of the medication, the unit of the dosage to be given, the number of dosage units, the time the medication is to be given, and how it is to be administered. (It is recommended the parent ask the pharmacist to provide 2 properly labeled containers- one for home and one for the center).

Over the counter medication shall be placed in the original container labeled with the child's name, the name of the medication, the dosage to be given and the time and method of administration.

Dietary supplements must be pre-measured by the parent and include specific written instructions by the parent, doctor, and/or nutritionist.

Please initial below:

________ I request a paper copy of the medication administration policy.

________ I declined a paper copy of the medication administration policy.

I have read and understand ABC of NC's medication administration policy and agree to abide by its guidelines.

____ ________________

Signature of Parent/Guardian Date

____ ________________

Signature of ABC of NC Witness Date

ABC of NC

Authorization for Medication Administration

Name of Client: ____ Date of Birth: __________________

TO BE COMPLETED BY PHYSICIAN/ MEDICAL PROVIDER

Prescribing Health Care Clinician: __________________________________Phone Number: _______________
In order to keep this client in optimum health and to help maintain maximum performance, it is necessary that this prescribed medication be given during program hours.

Type of medication: □ Prescription □ Emergency/ Rescue □ Over-the-Counter □ Dietary Supplement
Medication: _____________________________________ Dosage: ___________________________________
Time(s) medication is to be given at the center: ____

NOTE: "Lunch time" may vary between 11:30 am- 1:00pm
**If medication is to be given only as needed, please indicate specific circumstances when medication should be given: ____
Special instructions: ____
Side effects: ____

Emergency/ rescue medications (inhalers, Epi-pens, insulin, glucagon) will be kept in the room with the client or may be kept by the client.

□ YES □ NO Student understands the use of his/her emergency medication and has been instructed how to self-administer such medication.

Signature of Physician/ Medical Provider: ___________________________________ Date: ________________

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby give permission for my child, ________________________________, to receive the above prescribed medication during program hours. I agree to send the medication the center in a container originally labeled by a pharmacist and which has written on it: my child's name, the name of the medication, the dosage(s) to be given, and the time and manner the medication is to be given.
I hereby release the ABC of NC Child Development Center, and their employees and agent from any and all liability that may result from my child taking the above prescribed medication or for the loss of medication by my child while at the center or during program activities.

Signature of Parent/ Guardian: ____ Date: ________________
Phone Number of Parent/ Guardian: ______________________________________

ABC of NC

HIPAA (Health Insurance Portability and Accountability Act) CONSENT

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client information will be maintained by **ABC of NC Child Development Center** as described the Notice of Privacy Practices contained in the Compliance Program and in compliance with federal and state regulation. A copy of the Notice of Privacy Practices is available for review at time of intake, any subsequent appointments, or can be requested by contacting ABC of NC at 336-251-1180.

ABC of NC Child Development Center reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and, in general, for continuity of care. Disclosure of information may occur with a consent unless it is an emergency situation or for other exceptions as detailed in the General Statute or in CR 164.512 of HIPAA. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it with a signed release of information form.

We reserve the right to:

1. Call you to remind you of your next appointment and/or leave information on your voicemail.
2. Text or email you appointment reminders if your consent is on file (electronic communication policy).

If there is anyone that you would like us to share your health information with, other than a provider, agency, and/or school, please list the names below and circle what type of consents you wish to provide.

Name:	Scheduling	Billing/ Payments	Daily/ Treatment Progress	Interventions	Diagnostic Considerations
Name:	Scheduling	Billing/ Payments	Daily/ Treatment Progress	Interventions	Diagnostic Considerations

I have had the opportunity to read, understand, and ask questions about the Notice of Privacy Practices.

___________ I decline to keep the notice　　　　______________ I have kept the notice

____　　　　____________________

Signature of Client or Legal Guardian　　　　Date

____　　　　____________________

Print the Name of the Client　　　　Date of Birth

____　　　　Witness Signature

ABC of NC

Electronic Communication Policy

Email offers an easy and convenient way for therapist and client to communicate, but it can also introduce unique challenges into the therapist-client relationship. Below are some guidelines for contacting ABC of NC Child Development Center using email:

- For emergencies, consult an emergency room or mobile crisis. Do **NOT** use email for emergencies!
- Email is not a substitute for an appointment. If you need an appointment, please schedule a session.
- Appropriate use of email can include referrals and appointment scheduling requests.
- Email should **NOT** be used to communicate sensitive medical information such as: information regarding sexually transmitted diseases, AIDS/HIV, Mental Health, Developmental Disabilities, and/or Substance Abuse.
- Email is **NOT** confidential. Be aware that if you send emails from your work, your employer may be able to read your email.
- Email is part of your medical record.
- Either party can revoke permission to use the email system at any time.

Texting can also introduce some of the same challenges as email:

- Like email, texting is **NOT** a substitute for an appointment. If you need an appointment, please schedule a session.
- Because phones can be lost or stolen, it is imperative that you do not communicate information of a sensitive nature over text.
- Appropriate use of text is limited to appointment confirmations or appointment/ call requests.
- Clients should not text ABC of NC staff.
- ABC of NC may use texts or automated phone calls for appointment reminders

Please initial below:

______ I have read the above information and understand the limitations of electronic communication. I understand that ABC of NC may not be able to communicate with me electronically if there are concerns regarding confidentiality.

Please initial the appropriate lines. Put N/A or leave blank if you do permit this form of electronic communication.

__________ It is permissible for ABC of NC to contact me via email regarding scheduling.

__________ It is permissible for ABC of NC to contact me via text regarding scheduling.

__________ It is permissible for ABC of NC to forward your information about services, special programs, funding opportunities, special events, and the ABC of NC Newsletter.

Client Name: ____

Client or Guardian Signature: ________________________________ Date: ______________________

Email Address: ____ Cell Phone: __________________

Preferred Contact Method: __________________________________ OK to leave a message? Yes No

ABC of NC

Client Rights, Responsibilities, and Informed Consent

Statement of Client Rights ___________**Initials**

Clients have the right to:

- Be treated with dignity and respect.
- Fair treatment regardless of race, religion, gender, ethnicity, sexual orientation, age, disability, or source of payment.
- Have their treatment and other client information kept private. Only where permitted by law, records may be released with client permission.
- Easy access to timely care.
- Decisions about their care made without regard to financial incentive.
- Know about their treatment choices and share in developing their treatment options, and be given information about clinical guidelines used in providing and managing their care.
- A clear explanation of their condition and treatment.
- Information about their health care insurance coverage and, if applicable, its role in the treatment process.
- Ask their provider about their work history, training, and licensure.
- Freely file a complaint or appeal.
- If a minor, seek and receive periodic services from a physician without parental consent in accordance with G.S. 90-21.5.
- In the event that restrictive intervention is needed, per 27D .0303 (b), there must be informed written consent for planned use of a restrictive intervention. This would be included in the treatment plan.
- To request a copy of their treatment plan in writing allowing ABC of NC 7-10 business days to provide the information.
- Consent to treatment or refuse treatment.
-

Statement of Client Responsibilities ___________**Initials**

Clients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give provider information needed to deliver the best possible care.
- Ask questions about their care to help them understand the care being provided.
- Follow the treatment plan. The treatment plan is jointly created by client and provider.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments: __________ **Initials**
    1. *Clients that are more than 15 minutes late for an appointment will be charged the full-rate of the session and may need to be rescheduled.*
    2. *Clients should call the office as soon as they know they need to cancel a visit. Appointments cancelled with less than 24 hours may be charged a $60 fee.*

3. *Clients that do not show up for an appointment will be charged a $60 no-show fee and may receive a letter of dismissal.*

- Let the provider know when the treatment plan is no longer working for them.
- Openly report concerns about the quality of care they receive.
- Report abuse and fraud.

Risk/Benefits:

Psychological evaluation and treatment can have numerous benefits, including mental health, developmental disability, and substance abuse diagnoses and creating treatment goals to decrease symptoms associated with these conditions. Results from psychological evaluations can assist your doctors, therapists, and other health professionals in planning the most appropriate treatment interventions. Psychological interventions and evaluation risks can include questions that may cause some discomfort or bring up painful feelings as part of the process.

Informed Consent for Treatment:

I agree and consent to participate in behavioral health or educational assessments and evaluations, educational services, and/or behavioral health treatment services offered and provided by ABC of NC Child Development Center, including school and related services and/or outpatient mental health services. I understand that I am consenting and agreeing only to those services that ABC of NC staff is qualified to provide within the scope of their education, training, and licensure/certification. If the client is under the age of 18 or unable to consent to treatment, I attest that I have the legal authorization to initiate and consent for treatment on behalf of this individual. I have reviewed the emergency care information and client rights and responsibilities. A copy of this form will be provided to me upon request.

______________________________________ _________________________

Name of Client Date of Birth

______________________________________ _________________________

Signature of Legally Responsible Person Date

______________________________________ _________________________

Signature of ABC of NC Staff Witness Date

ABC of NC

Grievance Policy

If a client has a complaint or concern, the first action is to speak with a direct-care provider/supervisor (i.e. Program Supervisor, Psychologist, and Executive Director). ABC of NC supports open communication, therefore, clients should feel free to ask questions or express concerns at any time. Most issues can be resolved with personal communication.

Additionally, ABC of NC provides a confidential, legal, and fair procedure for clients to issue a grievance against ABC of NC staff and for those grievances to be resolved as so as possible. If the concern is not satisfactorily resolved, a formal complaint can be submitted directly to the Executive Director.

- The Executive Director will make every attempt to resolve the situation with the client.
- If the client is not satisfied with the Executive Director's resolution, the client may file a formal written complaint to the chair of the board of directors who will attempt to resolve the issue. The Client's Right Committee may be asked to convene and will attempt to address and make every effort to resolve the issue to the client's satisfaction.
- Clients always have the choice of leaving the program if they are not satisfied with the Client Rights Committee's resolution regarding the issue/complaint.
- In cases of suspected abuse, clients have the right to contact the Department of Social Services.
- Clients have the right to contact the North Carolina Governor's Advocacy Council at any time regarding their complaint or concerns.

Other agencies where complaints can be filed include:

NC Division of Health Services Regulations (DHHS)

Phone: 1-800-624-3004

Fax: 919-715-7724

Address: Complaint Intake Unit

2711 Mail Service Center

Raleigh, NC 27699-2711

NC Psychology Board

Complaint/Inquiry Form Online

Phone: 828-262-2258

Address: 895 State Farm Road, Suite 101

Boone, NC 28607

Disability Rights NC

Toll Free Phone #: 877-235-4210

Phone: 919-856-2195

TTY: 888-268-5535

Fax: 919-856-2244

Address: 2626 Glenwood Avenue, Suite 550

Raleigh, NC 27608

North Carolina Division of Non-Public Education

Phone: 919-733-4276

Address: 1309 Mail Service Center

Raleigh, NC 27699-1309

Please initial below:

______ I requested a paper copy of this grievance policy.

______ I declined a paper copy of this grievance policy.

ABC of NC

After-Hours Resources/ Emergency Care Information

Your wellness is our priority. If it is after business hours and your needs are urgent, but you cannot wait until your next scheduled appointment, you are welcome to leave a message on our confidential voicemail. 336-251-1180, ext. 105. We aim to respond to your phone calls within 24 hours. **If your needs require immediate attention or are life threatening, please call 911 or go directly to the closest Emergency Department.**

Mental health emergencies may also be directed to Mobile Crisis during business hours and after hours. Various counties in NC offer 24/7 crisis response or assessment services and are listed below by county served:

Guilford and Randolph County: Sandhills/ Therapeutic Alternatives 1-877-626-1772

Forsyth and Davie County: Forsyth Medical Center 1-800-718-3550 or CenterPoint Access Unit 1-888-581-9988

Davidson County Mobile Crisis: Cardinal Innovations/ Daymark 1-800-939-5911

24/7 Face-to-face Assessments available on site at the following hospitals:

Cone Behavioral Health Services (5 years old and up): 336-832-9700 or 1-800-711-2635; 700 Walter Reed Drive, Greensboro

Old Vineyard Behavioral Health Services (12 years old and up): 336-794-3550 or 1-855-234-5920; 3637 Old Vineyard Rd, Winston-Salem

Please initial below:

________ I request a copy of the after-hours resources and emergency care information.

________ I declined a copy of the after-hours resources and emergency care information.

I have read and understand the after-hours resources and emergency care information.

____ ___________________

Signature of Parent/Guardian Date

____ ___________________

Signature of ABC of NC Witness Date

ABC of NC

Photo/Video Release

I understand that photographs and/or videos may be taken as part of my child's client record and are the property of ABC of NC Child Development Center (ABC of NC). I understand that if I wish for my child's photos/videos to be used for additional purposes (e.g. training, marketing, etc.), I must give consent below. I also understand that any consent granted is effective from the date of the signature until I provide written notice of revocation. Any revocation of permission will be in effect for materials produced beyond the date of the revocation, but will not apply to materials produced by ABC of NC prior to the revocation of permission.

Client's full name: ____ Date of Birth: __________

Please initial below:

________I give permission for my child's photos/videos and client information/work to be used internally (e.g. display within the center, group photos, other clients' PECS books, staff training, etc.)

________ I give permission for my child's photos/videos and client information/work to be used externally (e.g. presentations, marketing materials, advertising, ABC of NC newsletter, etc.)

________ I give permission for my child's photos/videos and client information/work to be shared with partnering/collaborating agencies (e.g. Riverwood, The Engaging Educator, etc.)

________ I do NOT give permission for my child's photos/videos/etc. to be used for purposes other than client records.

Parent/Guardian Signature: ____________________________________ Date: ___________

ABC of NC

Permission for Child Pick-Up

ABC of NC only allows parents, legal guardians, or people designated by the parent(s) or legal guardian(s) to pick the client up from the center. Indicate below if you wish to give permission for someone other than the parent/guardian to pick up the client from the center. The designated person may be asked to show picture identification when s/he arrives to pick up the child. Any permission granted for child pick-up will remain effective until ABC of NC is notified in writing that below-listed person(s) are no longer permitted to transport the child from the ABC of NC premises.

__________________________________ has my permission to pick up my child,

(Name of person transporting child)

__________________________________ **from the ABC Child Development Center.**
(Child's name)

__________________________________ __________________
(Parent/guardian signature) **(Date)**

__________________________________ has my permission to pick up my child,

(Name of person transporting child)

__________________________________ **from the ABC Child Development Center.**
(Child's name)

__________________________________ __________________
(Parent/guardian signature) **(Date)**

__________________________________ has my permission to pick up my child,

(Name of person transporting child)

__________________________________ **from the ABC Child Development Center.**
(Child's name)

__________________________________ __________________
(Parent/guardian signature) **(Date)**

ABC of NC

Transportation & Outing Permission Form and Liability Release

☐ My/our child, ____, has permission to

(Client name)

participate in individualized treatment plan/education plan outings planned by staff of ABC of NC Child Development Center (ABC of NC). I/we understand that adequate adult supervision will be provided during these outings.

☐ My/our child, ____, has permission to

(Client name)

participate in ongoing transportation between the ABC of NC and the preschool or daycare center known as

____ and located at______________________________________.

(Facility name) (Facility address)

I/we understand that ABC of NC staff auto insurance provides primary coverage with secondary insurance provided by ABC of NC liability coverage for any events and/or damages not covered by ABC of NC staff automobile insurance.

I/we understand that these activities are designed to provide environmental stimulation, recreation or enjoyment and/or to work on goals from the client's individualized treatment plan/ education plan, at such times as ABC of Child Development Center staff feel that such outings would be in the best interest of the clients and their peers.

Liability Release

In consideration for allowing my/our child, ______________________________________, to participate in walking outings and auto transportation provided by ABC of NC, I/we hereby release ABC of NC, all employees of ABC of NC, and all volunteers who participate in the activities of the trips (directly related, as well as ancillary thereto,) from liability on my/our behalf and on behalf of my/our minor child, based on a claim of negligence arising in any way from my/our child's participation in the outings and activities which take place during the outings (i.e. all activities of whatever nature from the time my child leaves my care, custody and control in anticipation of the departure of the trips until the time my child is returned to my care, custody and control after the termination of the outings) except to the extent the injury is covered by any insurance procured by individual staff or by ABC of NC, which insurance does not allow for subrogation of the claim as against ABC of NC employees or volunteers alleged to have been negligent or to the extent and amount he injury is specifically covered by insurance providing coverage for the person or persons alleged to have been negligent. This release relates solely to ordinary negligence and does not apply to willful or wanton negligence or intentional misconduct on behalf of any employee or volunteer.

Additionally, I/we will specifically agree to indemnify and hold harmless, ABC of NC and employee or volunteer who participates in any aspect of the trips from any loss, damage, or demand sustained in any way related to my/our child's participation in the above designated trips whether from their alleged negligence or otherwise, except with respect to the individual employee or volunteer where the loss relates to willful or wanton negligence or willful misconduct of that ABC of NC employee or volunteer.

This release and indemnity as to ABC of NC is absolute to the extent not covered by insurance.

Parent/Guardian Printed Name ____

Parent/Guardian Signature ____

Date ________________

ABC of NC

Client Payment Policies

Thank you for choosing ABC of NC. We are pleased to participate in your care and look forward to establishing a lasting relationship as your primary provider of behavioral services. As part of this relationship, we wish to establish our expectations of your financial responsibility. Please read our policies, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Payment policies for diagnostic, therapeutic, and ABA therapy services (The Autism Clinic)**
   a. Payments are due in accordance with insurance policies and are billed on a fee-for-service basis.
   b. For diagnostic and therapeutic services, payment or copayment amounts are due at the time of services. We accept cash, checks, or credit cards.
   a. For ABA therapy services, payment or copayment amounts are due weekly on the Wednesday following the prior week of service, unless insurance company requirements are different. Payments are due upon receipt of statements; late fees will be charged. We accept cash, checks, or credit cards.
   b. Payments are to be delivered to the clinic office manager (Christie Ragan) or placed in the secure (colored) "Clinic Payments" drop box in the ABC of NC Autism Clinic. Payments for 1:1 ABA therapy should NOT be dropped in the "Tuition/Donations" drop box in the main building or given to a therapist or supervisor.
   c. When considering your options as to how you are billed, consider receiving invoices via email as it is the most efficient way for us to get them to you.
   d. Insurance Payments
      i. It is important for clients to be informed consumers, who understand the specifications of their insurance policies (e.g. coverage, referral/authorization requirements, etc.). The client's health insurance policy is a contract between the client and her/his Health Insurance Company or employer. It is the client's responsibility to know if her/his insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our providers participate.
      ii. Clients must present a current insurance card if a new card has been issued and/or if there are any changes to their coverage. As a courtesy to our clients, ABC of NC will bill your insurance company directly for behavioral health services rendered, provided we are credentialed with your insurance company for the specific service. If problems arise regarding coverage issues, we will attempt to work with the client's insurance company to help resolve them prior to making it the client's responsibility. However, clients are ultimately financially responsible for payment of behavioral health services rendered.
      iii. If you do not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement from ABC of NC if your insurance pays the claim at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicaid consider some services to be "noncovered," in which case you are responsible for payment in full.
      iv. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

v. According to NC Statute 58-3-225(b), insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed. If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.

vi. ABC of NC Child Development Center contracts with many insurance plans. Before your appointment, please confirm that we are considered in-network and the services are covered under your plan. If we are considered out-of-network, you will be billed for the cost of care.

vii. If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

e. *Attendance and Missed Appointments*

i. Clients and families are expected to arrive 5-10 minutes before their scheduled appointment. A parent/guardian must remain with the client until the client is in the therapist's care.

ii. Clients that are more than **15** minutes late for an appointment will be charged the full-rate of the session and/or may need to be rescheduled. Sessions that start late may not be billable to insurance.

iii. Clients should call the office as soon they know they need to cancel a visit. Appointments canceled with less than 24 hours notice may be charged a $60/hour fee.

iv. Clients who do not notify ABC of NC when they need to cancel an appointment will be charged a $60/hour No Show Fee.

f. *Chronic Absenteeism and Referral Policy*

i. Because the regular attendance of our clients is so important to the continuity and quality of care that we provide, clients and families who chronically cancel or miss their appointments/sessions and make no attempt to reschedule will be notified that they can no longer schedule appointments with ABC of NC. At this point, a client will be referred to another provider for services.

ii. ABC of NC reserves the right to refer families to another provider when there is chronic absenteeism.

iii. Before being referred to another provider, the family/client will receive a certified letter providing written notification that their chronic absenteeism or tardiness has been noted and that it is impacting the services provided by ABC of NC. If they continue to miss or cancel appointments, they will be referred to another provider.

2. School/Tuition-Based Services Payment Policies (ABC of NC School)

a. Tuition-based services include parent/professional education classes, team meetings, and quarterly home visits at no additional cost.

b. A deposit in the amount of one-month's tuition is required in order to hold a client's slot (current fees are available on the ABC of NC website). This deposit will be kept on hand throughout the duration of service delivery to ensure that ABC of NC receives a 30-day

notice of intent to discontinue services. The deposit, minus any outstanding balance for late-charges or other charges, will be returned to clients upon termination of services, provided that ABC of NC receives a 30-day written notice of intent to discontinue services. The deposit is forfeited if services are cancelled without a written 30-day notice.

c. Clients are responsible for payment in advance for services. Tuition will be billed for the next month on, or about, the 6th day of the current month.
d. If a client will be absent for all or part of a day, the parent/guardian should notify the front office by phone as soon as possible to ensure that the scheduling coordinator can adjust the daily schedule. Parents/ guardians should also notify the front office by phone if a client will be arriving late so that staff can remain productive throughout the day. As a courtesy, if a planned absence is changed, please provide at least 24 hours' notice to the front office so that the schedule can be readjusted to accommodate the client's attendance.
e. Tuition is non-refundable. No refunds will be issued for client absences, inclement weather days, or other occasions, nor can these days be made-up (with the exception of scheduled inclement weather make-up days). Due to complexities with scheduling, missed meetings due to holidays, school closings, cancellations, etc., will not be rescheduled.
f. Late Pick-Up Charges: Clients will be assessed a fee if the client is picked up late from school. During final dismissal (i.e. 2:45 pm), due to heavy traffic in the carpool line, late pick-up charges begin incurring at 2:55 pm and are charged at the following rates:
   i. $10.00 (5-14) minutes late
   ii. $50.00 (15-30) minutes late
   iii. $100.00 (31 or more) minutes late
g. Services not included in center-based tuition are charged in addition to the monthly tuition. These charges are billed in quarter-hour increments following the provision of services. Hourly service rates apply.

I have read and understand the ABC of NC Autism Clinic's client payment policies and agree to abide by its guidelines.

____ ____________________

Signature of client/responsible party Date

____ ____________________

Signature of ABC of NC staff witness Date

ABC of NC

AUTHORIZATION FOR 2 WAY RELEASE OF PROTECTED HEALTH INFORMATION

I authorize **ABC of NC Child Development Center** to release my behavioral health and/or educational records to:

Name: ____

(PCP, referring doctor, school agency, employer, etc.; list one per release form)

Address: ____

Phone: ________________________________ Fax: ____

AND I authorize: ____

(PCP, referring doctor, school agency, employer, etc.)

to release my behavioral health and/or educational records to **ABC of NC Child Development Center** to provide coordination of care.

THESE RECORDS SHALL INCLUDE: psychological evaluation report(s) including mental health, developmental disability, and/or substance abuse diagnoses and any other information specified:

____

REVOCATION- *I understand that I have the right to revoke this authorization at any time by giving written notification to ABC of NC Child Development Center. However, the revocation will not be effective to the extent that action has been taken in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a right to contest a claim.*

I understand that the psychologist may not condition psychological services upon my signing any authorization unless these psychological services are provided to me for the purpose of creating health information for a third party (e.g. insurance company).

I understand that if my record contains information relating to HIV infection, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information.

I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule. However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not redisclose such information without my further written authorization unless otherwise provided for by state or federal law.

____ _______________________________________

Client Date of Birth

____ _______________________________________

Legal Representative/ Guardian if applicable Relationship to Client

This authorization shall remain in effect for one year unless otherwise specified.

Date of expiration: ____

Witness: ____

Date of signature: ____