INSTRUCTIONS

To use this form, click on the header space above and input the name and medical record number for the individual applying for services. If there is additional information you would like to have on each page, you can type in the additional cells. Also, please type in your program name and telephone number in the footer section to identify your program. The Filename & Path and pagination are autotext and should not be adjusted.

Once the header and footer are set, you can either print out the document and complete by hand, or save the document as a form and tab through the fields on the computer. You may protect the document by going to "Tools", then click "Protect Document". This will enable you to tab through each of the fields. There is no allowance for electronic signatures on this form, however.

The entire application packet may not be applicable for your service/service line. If that is the case, simply select those pages which apply. General information pages have been grouped towards the beginning of the document, with more specific information towards the back.

Service line-specific addenda are located in a separate file.

*** Each individual should be introduced to and made aware of Self-Advocacy information. Refer to Self-Advocacy ppt.

RIGHTS OF PERSONS SERVED

I was provided the handouts listed below and verbally explained my rights as a recipient of services. I understand my right to file a grievance if I am unhappy with the service provided or decisions made by others regarding the services provided. I understand it is my responsibility to notify GPSBHS of changes needed in my plan of care, schedule or issues with GPSBHS representatives**.**

Title	**Instructions**
Rights of Persons Served	For you to keep.
Rights and Privacy	For you to keep.
Grievance Documentation Form	For your use if you have a general complaint about services.
Notice of Privacy Practices	For you to keep.
PHI - Individual Requests	For your use if you have a complaint about your privacy.
Privacy Complaint Form	For you to keep.
Voter Registration Information	For your use if you are eligible to vote, but are not registered.
Discharge Policy Handout	For you to keep.

Name:
DOB:
MR #:
Medicaid #:

______ **Initials**

HABILITATION PLANNING
I have been informed of my right to, within thirty days of admission to an GPSBHS program to have an individual written treatment plan.
______ **Initials**

DISCHARGE PLANNING
I have been informed of my right to participate in discharge planning process and have a written discharge plan at time of discharge that includes recommendations for other services.
______ **Initials**

EMERGENCY / SAFETY INTERVENTIONS
I have been informed that GPSBHS may implement the use of an Emergency / Safety Intervention in the case of an emergency. I consent to the use of emergency / restrictive intervention when needed to ensure the individuals safety.
______ **Initials**

NON-SOLICITAION AGREEMENT
Upon discontinuing services with GPSBHS, I Agree that I will not solicit or privately hire GPSBHS representatives for up to 90 days following discharge.
______ **Initials**

I hereby affirm that the above noted initials are mine and that I agree to the consents included. I also understand that I may withdraw any of my consent(s) at any time, either verbally or in writing.

____ ____________________
Signature of Legally Responsible Person **Date**

Consents must be completed annually from the date of signature above, or in the event of a change in guardianship.

Name:
DOB:
MR #:
Medicaid #:

RELEASE OF INFORMATION

Name: ______________________ DOB: __________ Record #: __________

I, ______________________ (Individual or Legally Responsible Person)

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

Name: ______________________ Agency (if any): ______________________

Address: ____

Phone #: ______________________ Fax #: ______________________

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

Treatment Referral Payment Other: ______________

Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:

Initial	Information to be Disclosed	Initial	Information to be Disclosed
	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Progress Note Documentation
	Medical History and Physical		Alcohol/Drug Treatment Information*
	Discharge Summary		Verbal Communication
	HIV / AIDS**		Other:

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.* GPSBHS may not confirm or deny a person's treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.**I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient's handling of that information.** This authorization will automatically expire on: (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Name:
DOB:
MR #:
Medicaid #:

____ ____________________
Signature of Person Served Date

____ ____________________
Signature of Legally Responsible Person (if not self) Date

____ ____________________
GPSBHS Representative Date

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.
**Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.
A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered to be as valid as the origin

Name:
DOB:
MR #:
Medicaid #:

RELEASE OF INFORMATION FOR PRIMARY CARE PHYSICIAN OR CCNC/CA

Name: DOB: Record #:

I, (Individual or Legally Responsible Person)

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

Name: Agency (if any):

Address:

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

Treatment Referral Payment Other:

Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:

Initial	Information to be Disclosed	Initial	Information to be Disclosed
	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Progress Note Documentation
	Medical History and Physical		Alcohol/Drug Treatment Information*
	Discharge Summary		Verbal Communication
	HIV / AIDS**		Other:

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.* GPSBHS may not confirm or deny a person's treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient's handling of that information.

This authorization will automatically expire on: ____________________ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

____ ______________________

Signature of Person Served Date

Program Office: **Contact Number:**

Name:
DOB:
MR #:
Medicaid #:

____ ____________________
Signature of Legally Responsible Person (if not self) Date

____ ____________________
GPSBHS Representative Date

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.
**Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.
A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered to be as valid as the origin

Name:
DOB:
MR #:
Medicaid #:

CONSENT FOR TREATMENT

Service Title　　　　Program Supervisor

I have been informed of the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability. I hereby give my consent for Great Place to Start Behavioral Health Services (GPSBHS) to provide the above named services to the above named individual. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. In addition, I understand I may refuse any services offered at any time without threat or termination of services. In addition, I have been informed that I may contact at my own expense, private physicians, private MH/DD/SA professionals or legal counsel.
______ Initials

FINANCIAL RELEASE OF INFORMATION

I understand that GPSBHS may use confidential information about me to bill and be paid for services. I hereby consent for GPSBHS to release information to the funding source(s) for this purpose. I understand that it is my responsibility to notify GPSBHS within 24 hours of any information I receive regarding changes in my Medicaid or other funds that adversely affect the reimbursement of agency services.
______ Initials

PERMISSION TO PROVIDE TRANSPORTATION

I hereby grant permission for GPSBHS contractors and representatives to provide transportation to the above named service recipient, and agree to hold GPSBHS harmless for any accident/injury that results from the provision of transportation.
______ Initials

PERMISSION TO SEEK EMERGENCY CARE

I hereby give consent for my GPSBHS representative to seek and sign consent for emergency medical care if the above named person is unable to do so for themselves. It is understood that the GPSBHS representative will attempt to locate next of kin, or other legally responsible adult, as quickly as is possible in the emergency situation.

Preferred Care Facility: ______________________________

______ Initials

CONTACT PREFERENCES

I understand that one of my rights as a person served is to choose how I am contacted. I *DO/DO NOT (please circle one)* give permission for GPSBHS representative to contact me at work. Furthermore, I *DO/DO NOT (please circle one)* give permission for GPSBHS representatives to leave voice messages for me at *HOME/WORK/BOTH/NEITHER (please circle one)*.

My preferred contact numbers are:

1st Choice　　　　2nd Choice

Name:
DOB:
MR #:
Medicaid #:

____ ____________________
Signature of Legally Responsible Person **Date**

Name:
DOB:
MR #:
Medicaid #:

RELEASE OF INFORMATION FOR SCHOOL

Name: DOB: Record #:

I, (Individual or Legally Responsible Person)

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

Name: Agency (if any):

Address:

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

Treatment Referral Payment Other:

Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:

Initial	Information to be Disclosed	Initial	Information to be Disclosed
	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Progress Note Documentation
	Medical History and Physical		Alcohol/Drug Treatment Information*
	Discharge Summary		Verbal Communication
	HIV / AIDS**		Other:

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.* GPSBHS may not confirm or deny a person's treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient's handling of that information.

This authorization will automatically expire on: ____________________ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

____ ______________________

Signature of Person Served Date

Program Office: **Contact Number:**

____ ____________________

Signature of Legally Responsible Person (if not self) Date

____ ____________________

GPSBHS Representative Date

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.
**Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.
A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

RELEASE OF INFORMATION FOR PSYCHIATRIST/NP

Name: ______________________ DOB: __________ Record #: __________

I, ______________________________ (Individual or Legally Responsible Person)

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

Name: ______________________ Agency (if any): ______________________

Address: ____

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

Treatment Referral Payment Other: __________________

Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:

Initial	Information to be Disclosed	Initial	Information to be Disclosed
	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Progress Note Documentation
	Medical History and Physical		Alcohol/Drug Treatment Information*
	Discharge Summary		Verbal Communication
	HIV / AIDS**		Other:

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.* GPSBHS may not confirm or deny a person's treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient's handling of that information.

This authorization will automatically expire on: ____________________ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

____ ____________________

Signature of Person Served Date

Name:
DOB:
MR #:
Medicaid #:

____ ____________________
Signature of Legally Responsible Person (if not self) Date

____ ____________________
GPSBHS Representative Date

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.
**Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.
A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

RELEASE OF INFORMATION FOR BEHAVIORAL AGENCY

Name: DOB: Record #:

I, (Individual or Legally Responsible Person)

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

Name: Agency (if any):

Address:

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

Treatment Referral Payment Other:

Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:

Initial	Information to be Disclosed	Initial	Information to be Disclosed
	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Progress Note Documentation
	Medical History and Physical		Alcohol/Drug Treatment Information*
	Discharge Summary		Verbal Communication
	HIV / AIDS**		Other:

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.* GPSBHS may not confirm or deny a person's treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient's handling of that information.

This authorization will automatically expire on: ____________________ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

____ ____________________

Signature of Person Served Date

GENERAL SERVICE APPLICATON

Name:
DOB:
MR #:
Medicaid #:

____ ____________________
Signature of Legally Responsible Person (if not self) Date

____ ____________________
GPSBHS Representative Date

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.
**Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.
A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

Name:
DOB:
MR #:
Medicaid #:

RELEASE OF INFORMATION HOSPITAL

Name: DOB: Record #:

I, (Individual or Legally Responsible Person)

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

Name: Agency (if any):

Address:

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

Treatment Referral Payment Other:

Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:

Initial	Information to be Disclosed	Initial	Information to be Disclosed
	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Progress Note Documentation
	Medical History and Physical		Alcohol/Drug Treatment Information*
	Discharge Summary		Verbal Communication
	HIV / AIDS**		Other:

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.* GPSBHS may not confirm or deny a person's treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient's handling of that information.

This authorization will automatically expire on: ____________________ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Signature of Person Served Date

Program Office: **Contact Number:**

GENERAL SERVICE APPLICATON

Name:
DOB:
MR #:
Medicaid #:

____ ____________________
Signature of Legally Responsible Person (if not self) Date

____ ____________________
GPSBHS Representative Date

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.
**Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.
A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

GENERAL SERVICE APPLICATON

Name:
DOB:
MR #:
Medicaid #:

RELEASE OF INFORMATION

Name: ______________________ DOB: __________ Record #: __________

I, ______________________________ (Individual or Legally Responsible Person)

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

Name: ______________________ Agency (if any): ______________________

Address: ____

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

Treatment Referral Payment Other: ____________________

Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:

Initial	Information to be Disclosed	Initial	Information to be Disclosed
	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Progress Note Documentation
	Medical History and Physical		Alcohol/Drug Treatment Information*
	Discharge Summary		Verbal Communication
	HIV / AIDS**		Other:

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.* GPSBHS may not confirm or deny a person's treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient's handling of that information.

This authorization will automatically expire on: ____________________ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

____ ____________________

Signature of Person Served Date

Program Office: **Contact Number:**

Name:
DOB:
MR #:
Medicaid #:

____ ____________________
Signature of Legally Responsible Person (if not self) Date

____ ____________________
GPSBHS Representative Date

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.
**Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.
A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

RELEASE OF INFORMATION FOR MCO

Name: DOB: Record #:

I, (Individual or Legally Responsible Person)

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

Name: Agency (if any):

Address:

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

Treatment Referral Payment Other:

Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:

Initial	Information to be Disclosed	Initial	Information to be Disclosed
	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Progress Note Documentation
	Medical History and Physical		Alcohol/Drug Treatment Information*
	Discharge Summary		Verbal Communication
	HIV / AIDS**		Other:

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.* GPSBHS may not confirm or deny a person's treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient's handling of that information.

This authorization will automatically expire on: ____________________ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

____ ______________________

Signature of Person Served Date

GENERAL SERVICE APPLICATON

Name:
DOB:
MR #:
Medicaid #:

____ ____________________
Signature of Legally Responsible Person (if not self) Date

____ ____________________
GPSBHS Representative Date

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.
**Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.
A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

Name:
DOB:
MR #:
Medicaid #:

Client Rights and Responsibilities

Great Place to Start Behavioral Health Services, PLLC
1425 S Glenburnie RD Suite 3C
New Bern, NC 28562

This document summarizes your rights and responsibilities as a client of Great Place to Start Behavioral Health Services, PLLC. Please take a moment to review this information. If you have any questions, Great Place to Start Behavioral Health will be happy to discuss them with you. After you sign this document, you will be provided a copy for your records if you would like to have one. Please ask Great Place to Start Behavioral Health to make you a copy if you wish to have one.

Client Rights

1. You have the right to confidentiality of you and your child's personal and treatment related information. Our Notice of Privacy Practices provides detailed information on how we use your personal information. A copy of our Notice of Privacy Practices will be provided to you at the beginning of your treatment with Great Place to Start Behavioral Health Services.

1. You have the right to care that is coordinated with your other health care providers. Upon signed release of information, Great Place to Start Behavioral Health Services will work closely with your primary care physician and other medical providers as indicated. In some instances, it may be helpful for Great Place to Start Behavioral Health to speak to your spouse / life partner, family member, or close friend; however, this would occur only with your knowledge and signed consent. Please do not hesitate to discuss this with Great Place to Start Behavioral Health Services should you have any questions.

1. You have a right to privacy, security, and respect for property.

1. You have the right to be protected from abuse, neglect, exploitation, or humiliation. You have the right to contact Disability Rights North Carolina.
   Disability Rights North Carolina
   Toll-Free: 877-235-4210
   Phone: 919-856-2195
   TTY: 888-268-5535
   Fax: (919) 856-2244
   Email: info@disabilityrightsnc.org

Mailing Address:
2626 Glenwood Avenue, Suite 550
Raleigh, NC 27608

1. You have the right to be free from retaliation for making complaints or reports over suspected abuse, neglect, or exploitation.
2. You have the right to have timely access to, review, and obtain copies of pertinent information needed to make decisions regarding treatment or services. You have a right to an individualized written treatment plan. Our Notice of Privacy Practices provides greater detail regarding your right to access information in your clinical chart. A copy of our Notice of Privacy Practices will be provided to you at the beginning of your treatment with Great Place to Start Behavioral Health Services.

1. You have the right to make informed consent, to refuse care, and to express choices and preferences regarding your participation in your treatment to the extent permitted by law.

1. You have the right to access or obtain a referral to legal representation

1. You have the right to access self-help, support, and advocacy services

1. You have the right to investigation and resolution of complaints and alleged infringement upon your rights. You have the right to a grievance procedure that includes the right to: make complaints, be informed of decisions in response to complaints, and be informed of procedures to appeal decisions. Our grievance procedures are as follows:
   a. Complaints / grievances may be made verbally or in writing
   b. Complaints / grievances may be made to your treatment provider or to the office manager
   c. All efforts are made to resolve complaints immediately upon notification
   d. Complaints / grievances are reviewed by your treating clinician, the office manager, and the owner of the practice as applicable
   e. You will be informed of the result of the complaint / grievance investigation within 2 weeks. On request, this will be provided in writing.
   f. You may appeal the results of this decision to the owner of the practice. Appeals must be in writing.
   g. You will be informed of the decision of the appeal in writing within 2 weeks.

1. You have the right to receive treatment in the least restrictive environment.

1. You have the right to adequate and humane care.

Name:
DOB:
MR #:
Medicaid #:

1. You have the right to evidence-based information about alternative treatment / services.

1. You have the right to information about the cost of services that will be billed to your insurance carrier(s) or to you directly.

1. You have the right to access to 24-hour crisis intervention. To access crisis services, call Laquita Courman, at 252-349-2154. You may also call mobile crisis at 855-345-1200. If you are experiencing a medical emergency, please dial 911 or visit your closest emergency room.

1. You have the right to equal access to treatment / services regardless of race, ethnicity, gender, age, sexual orientation, or source of payment. You have a right to medical care and habilitation regardless of your degree of disability.

Client Responsibilities

The following are your responsibilities as a client in treatment with Great Place to Start Behavioral Health Services.

1. You have a responsibility to provide accurate information to your treating clinician(s) to the best of your knowledge, including information about your history, symptoms, past and current treatment, medications, side effects, and other matters related to you or child's health.

1. You have the responsibility to provide us with the name and contact information for a person you would like us to contact in the event of an emergency.

Emergency Contact: ____ Phone: __________________________

Relationship to Patient: _____________________________________

1. You have the responsibility to let your clinician know if you understand the treatment and what is expected of you.

1. You have the responsibility to inform us if there are any changes in your insurance, contact information, or health status.

Name:
DOB:
MR #:
Medicaid #:

1. You have the responsibility to pay any balances owed for fees or copayments at the time of service. If you are unable to make these payments, Great Place to Start Behavioral Health Services will make efforts to develop a payment plan with you.

1. You have the responsibility to be considerate of the rights or other individuals receiving services within the office building of Great Place to Start Behavioral Health Services and their staff. This includes control of noise, smoking (only permitted outside and away from the doorway), and managing the behavior of accompanying guests / children. We request that cell phone usage be kept to a minimum in the waiting area and that cell phone be turned off or placed in silent mode in treatment areas.

1. You have the responsibility to comply with you and your child's treatment plan, including follow up care. This includes keeping appointments on time and notifying the provider when appointments cannot be kept. If you are unable to keep your scheduled appointment, please call or text as soon as you are aware that you cannot make your appointment. Missing 2 scheduled appointments without notifying Great Place to Start Behavioral Health Services in advance could result in restricted scheduling of future appointments. Great Place to Start Behavioral Health Services does realize extenuating circumstances may result in missed appointments, and these circumstances will be taken into consideration.

1. You are responsible for providing supervision for your child while at Great Place to Start Behavioral health Services. If you are here for your child's initial assessment, and your child is under the age of 6 or if you bring any other children under the age of 6, another adult must accompany you to supervise the child/children in the waiting area while you are being interviewed.

2. You have the responsibility to report recommendations, questions, or concerns about your treatment to your provider.

1. Participation in illegal or disruptive behavior on Great Place to Start Behavioral Health Services grounds is prohibited. Any defacing, destruction, or theft of personal property of Great Place to Start Behavioral Health Services, their staff / providers, or other clients will not be tolerated. Any threat or act of violence directed towards staff, other clients, or visitors is grounds for immediate dismissal from services by Great Place to Start Behavioral Health Services.

1. Weapons Prohibited: All persons who enter these premises are restricted from carrying a handgun, firearm, or prohibited weapon of any kind **regardless of whether the person is licensed to carry a handgun or not**. Prohibited weapons include any form of weapon or

explosive restricted under local, state, or federal regulation including all firearms, illegal knives, or other weapons covered by the law. Violations will result in dismissal from my practice.

1. Selling, distribution, or use of drugs on the grounds of Great Place to Start Behavioral Health Services is grounds for immediate dismissal from services. Medication samples provided to you by your doctor are for your use only and may not be shared, sold, or transferred to another person under any circumstances.

1. Please do not leave your purse, phone, tablet or other valuables in the waiting room unattended. A Great Place to Start Behavioral Health Services is not responsible for loss, theft, or damage of any personal property.

I have had the opportunity to review and ask questions about these rights and responsibilities. I understand that I can request a copy of this document at any time.

My signature confirms that I understand my rights and responsibilities as a client of Great Place to Start Behavioral Health.

Client Printed Name: ____

Client Signature:____ Date:________

Guardian Signature:____ Date:________
(For clients under 18)

Staff Signature:____ Date:________