LORVEN CHILD AND FAMILY DEVELOPMENT

Client Information

Date: _____ Client Name: _____

Date of birth: _____ Social Security #: _____

Ethnicity: _____ Gender: ❑ Male ❑ Female

Parent/Legal Guardian: _____ Relationship:_____

Address: _____ City/State/Zip: _____

Other Parent Name: _____

Address: _____ City/State/Zip: _____

Child Protective Services worker (name and phone number, if applicable): _____

_____

Home phone: _____ OK to leave messages ❑ YES ❑ NO

Cell phone: _____ OK to leave messages ❑ YES ❑ NO

Work phone: _____ OK to leave messages ❑ YES ❑ NO

Email: _____

Employer: _____

Insurance:_____ ID #: _____

Doctor:_____ Date of Last Exam: _____

Allergies: ❑ YES ❑ NO If yes, please list:_____

List Medications: _____

_____

LORVEN CHILD AND FAMILY DEVELOPMENT

Consent for Services

You can expect *Lorven Child and Family Development* to provide professional services delivered in a respectful manner. Our goal is to ensure you receive client-centered treatment that encourages your participation.

- I hereby give my consent for treatment and/or services to be provided by *Lorven Child and Family Development.*
- I understand that I may refuse services at any time and that I can refuse a therapeutic modality without the threat of termination or discharge. If *Lorven Child and Family Development* does not offer an alternative therapeutic approach that is right for you, we will assist with referrals and/or recommendations that can best meet your needs.
- I acknowledge that confidentiality has been verbally explained, as well as limits to confidentiality as described in Client Rights; I understand that the provision of services is not contingent upon such consent and of the need for such release. I understand that confidential information may not be disclosed without written consent when federal statutes prohibit that release.
- I have received a copy of my rights as a client including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability.
- I understand that I have the right to access behavioral health crisis services 24/7 by reaching 336-659-3030.
- I understand that I have the right to an individualized written treatment plan and may have access to my service plan at any time by asking my therapist or Director.
- I give my consent for *Lorven Child and Family Development* to access emergency medical care, in case of medical emergency during session.
- I understand that participation in treatment is necessary in order to achieve goals. Therefore, if I miss three scheduled appointments without giving 24 hours notice, *Lorven Child and Family Development* may refer me to another agency.
- We understand that parents may seek treatment for their child(ren) who are experiencing problems with separation and divorce. *Lorven Child and Family Development* does not offer counseling to any child or family until a permanent custody order is in place. Please be aware that the focus of treatment at *Lorven Child and Family Development* will be to assist your child(ren), as well as yourself, to deal with issues **after** custody has been determined. When a therapist is required to testify in Court regarding treatment, it no longer protects client/therapist confidentiality and diminishes the foundation of trust that is critical to the treatment process. **Please be aware that if the therapist is subpoenaed to Court, we have a $500 retainer fee and bill at a rate of $150 per hour for each hour spent in preparation, Court appearance, travel time and/or testimony.**

_____

Signature of Client, Parent or Guardian Date

Client: Record No.: Date of Birth:

LORVEN CHILD AND FAMILY DEVELOPMENT

Authorization for Use and Disclosure of Protected Health Information

This authorization form implements the requirements for client authorization to use and disclose health information protected by the 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 state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I, _____ *(name of client or client's legally responsible person)*
authorize **Lorven Child and Family Development** to use or disclose to/with

Doctor: _____
(name of doctor to whom the requested use or disclosure will be made)

THIS DATA SHALL INCLUDE *(CLIENT MUST INITIAL BESIDE DATA TO BE USED OR DISCLOSED)*

___Assessments	___Service Notes	___Substance Abuse/Treatment
___Psychiatric Evaluations	___Service Plans/Goals	___HIV/AIDS Information
___Psychological Evaluations	___Discharge Summary	___Social, Developmental, Medical History
___Diagnoses	___Financial/Reimbursement	___Other:_____

PURPOSE OF USE OR DISCLOSURE *(CLIENT MUST INITIAL BESIDE DATA TO BE USED OR DISCLOSED)*

___At the request of the individual ___Assessment/Evaluation ___Coordination of Service
___Court Proceedings ___Determination of Benefits___Other:_____
Information requested should be mailed to this address: _____
_____

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C), substance abuse treatment information protected by federal law (42 C.F.R. Part 2), or HIV/AIDS information (G.S. 130A-143), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these three laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

Initial Authorizing the Release of Substance Abuse Treatment Information _____

Initial Authorizing the Release of HIV/AIDS Treatment Information _____

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Notice of Privacy Practices, a copy of which has been given to me. If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

_____ _____
Date of expiration, if less than one year Event, if less than one year

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that *Lorven Child and Family Development,* will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____
Signature of client Date Staff signature Date

_____
Signature of legally responsible person, if required Date

Client: Record No.: Date of Birth:

LORVEN CHILD AND FAMILY DEVELOPMENT

Authorization for Use and Disclosure of Protected Health Information

This authorization form implements the requirements for client authorization to use and disclose health information protected by the 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 state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I, _____ *(name of client or client's legally responsible person)*
authorize **Lorven Child and Family Development** to use or disclose to/with

Insurance Company: _____
(name of insurance company to whom the requested use or disclosure will be made)

THIS DATA SHALL INCLUDE *(CLIENT MUST INITIAL BESIDE DATA TO BE USED OR DISCLOSED)*

___Assessments	___Service Notes	___Substance Abuse/Treatment
___Psychiatric Evaluations	___Service Plans/Goals	___HIV/AIDS Information
___Psychological Evaluations	___Discharge Summary	___Social, Developmental, Medical History
___Diagnoses	___Financial/Reimbursement	___Other:_____

PURPOSE OF USE OR DISCLOSURE *(CLIENT MUST INITIAL BESIDE DATA TO BE USED OR DISCLOSED)*

___At the request of the individual	___Assessment/Evaluation	___Coordination of Service
___Court Proceedings	___Determination of Benefits	___Other:_____

Information requested should be mailed to this address: _____
_____

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C), substance abuse treatment information protected by federal law (42 C.F.R. Part 2), or HIV/AIDS information (G.S. 130A-143), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these three laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

Initial Authorizing the Release of Substance Abuse Treatment Information _____

Initial Authorizing the Release of HIV/AIDS Treatment Information _____

REVOCATION AND EXPIRATION

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_____ _____
Signature of client Date Staff signature Date

_____
Signature of legally responsible person, if required Date

Client: Record No.: Date of Birth:

LORVEN CHILD AND FAMILY DEVELOPMENT

Agreement to Pay

- ❑ I agree to pay for services that I receive at *Lorven Child and Family Development* (including individual, couples and family therapy, collateral contact and court appearances). I agree that it is my responsibility to inform *Lorven Child and Family Development* of any change that may affect my co-pay. This may include, but is not limited to, change in income, change in insurance or Medicaid coverage, etc. Failure to notify *Lorven Child and Family Development* of such changes may result in my fee reverting to the fees listed below.

The fee for Intake =	$150.00
The fee for Individual and Play Therapy =	$100.00 per 45 mins.
The fee for Individual and Play Therapy =	$160.00 per 75 mins.
The fee for Family Therapy with or without client =	$100.00
Court Appearance/Testimony =	$500.00 retainer fee & $150.00 per hour (min. 2 hours)
Collateral Contact =	$60.00 per hour
My insurance coverage =	$_____ per visit
My co-pay =	$_____ per session
QEEG Brain Map =	$250.00
Additional QEEG Brain Map =	$175.00
Neurofeedback Session =	$75.00

- ❑ I agree that I will pay $_____ per session.

- ❑ I authorize *Lorven Child and Family Development* to bill **Medicaid/Health Choice** for services provided by this company. It is my responsibility to report any changes in my insurance status and any information about additional insurance coverage to *Lorven Child and Family Development*. I will be responsible for any charges incurred as a result of failure to notify *Lorven Child and Family Development* of any insurance status.

- ❑ **Authorization to Collect Insurance -** I authorize *Lorven Child and Family Development* to release only information necessary to process insurance claims on services provided by this company. I authorize this office to apply for benefits on my behalf for covered services rendered and request that payment from my insurance company be made directly to *Lorven Child and Family Development.* I understand that it is my responsibility to notify *Lorven Child and Family Development* of any change in my insurance coverage or benefits. I understand that I may be responsible for claims not paid by my insurance company as a result of such change.

_____

Signature of Client, Parent or Guardian Date

Client: Record No.: Date of Birth: