

Client Name: _____

DOB: _____

Insurance # _____

Thank you for choosing Oliver's Contracting, Consulting, and Counseling Services, PLLC.
Please fully complete the information in this packet. It will be helpful in completing your assessment.

IDENTIFYING INFORMATION

1. Name: _____

First Name

MI

Last Name

Legal Guardian: _____

2. Gender: Female _____ Male _____ (check one)

3. Date of Birth ____/____/____

4. Address: _____

City, state, Zip Code: _____

5. Race: African American ____ Caucasian ____ Hispanic ____ Native American ____ Other ____

6. Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

7. Home Phone Number () _____ - _____

8. Mobile Phone Number () _____ - _____

9. Insurance Number _____

10. Social Security Number _____ - _____ - _____

11. Health Choice Number: _____

CLIENT EMERGENCY INFORMATION

Emergency Contact

Address

Telephone Number

Alternate Number

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ASSESSMENT OF NEEDS (p.2-4)

Why are you seeking services at this time?

Below is a list of symptoms or problems. Please mark the problems that you are experiencing at this time. Check all that apply to you:

Restless, edgy, keyed up	Tiring easily	Heart pounding, racing
Increased muscle tension	Trouble sleeping	2-3 hours of sleep
Chest pain/discomfort	Irritability	Numbness, tingling
Phobic Behavior	Sadness	Hopelessness
Worthlessness	Guilt	Agitation
Crying Spells	Anger outbursts	Suicidal Ideation
Choking sensation	Low Self-Esteem	Racing Thoughts
Hallucinations	Visual Hallucinations	Auditory
Fighting	Destroy Property	Self Injury
Cutting	Substance abuse	Major Shift in eating habits

Conflict w/Siblings	Conflict w/Children	Conflict w/Peers
Divorce, Separation	Visitation/custody dispute	
Conflict w/Parents	Conflict w/Peers	No/ Few friends
Family Desertion	Neglect/Abuse	Victim Offender
Recent Death of family member or friend		

Hyperactivity	Impulsiveness	Short Attention Span
Academic Problems	Behavioral Problems	_____
Argumentative	Annoys Others	Difficulty waiting turn
Often interrupting/intruding on others-butts into conversations		
Repeated distressing dreams	Intrusive, distressing thoughts, images	

Difficulty comprehending	slowed processing
Problems with organization	Problems emotional regulation
Problems with social boundaries	intermittent concentration
Problems with judgment	Trouble remembering names, faces, places
Other list below	

Does this information need to be sent to another agency? _____

If yes, then which agency or individual needs to be notified?

As part of respecting your privacy, you will be asked to complete a release of information form

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for Oliver's Contracting, Consulting, and Counseling Services, PLLC to exchange information with the agency or individual.

This page concerns medical issues. Please check if you experience now or have experienced any of these conditions.

Medical Conditions	
Anemia	Arthritis
Hernia	STD
Visual Problems	Hearing Problems
Anorexia/Bulimia	High Blood Pressure
Impaired Coordination	Asthma
Breathing Problems	COPD
Loss of Consciousness	Cancer
Memory Problems	
Diabetes Type I Type II	
Migraine	Digestive problems
Movement problems	
Dizziness	Seizures
Enuresis/Encopresis	
Sickle Cell Anemia	Heart Problems
Sinus Problems	Thyroid problems
Other: specify: _____	

Nutritional Scale:
I have an illness or condition that made me change the kind and/or amount of food I eat. Yes (2) No
I eat fewer than 2 meals per day Yes (3) No
I eat few fruits or vegetables, or milk products. Yes (2) No
I have 3 or more drinks of beer, liquor, or wine almost every day Yes (2) No
I have tooth or mouth problems that make it hard for me to eat Yes (2) No
I don't always have enough money to buy the food I need Yes (4) No
I eat alone most of the time Yes (1) No
I take 3 or more different prescribed or over-the-counter drugs a day. Yes (1) No
Without wanting to, I have lost or gained 10 pounds in the last 6 months Yes (2) No
I am not always physically able to shop, cook and/or feed myself Yes (2) No
Date of Last Physical Exam: _____
Physician Practice Name & Address: _____
Number (including area code): _____

Thank you for completing this basic information.

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Identifying Marks or Scars: _____

Height _____ Weight: _____ Hair Color _____ Eye Color _____

Medical Alerts _____

Allergies: _____ Symptoms of Adverse Reactions: _____

Seizures: _____ Hepatitis B Carrier: _____ Diabetes: _____ Hypertension _____

Other: _____

Medications:

Name	Dosage

Significant Issues: Physical Aggression___ Verbal Aggression___ Property Destruction___
Stealing___ DJJ Involvement___ DSS Involvement___ DD_____

Your Preferred Physician or Emergency place of service:

Doctor (name): _____ Facility Location: _____

Address: _____ Phone Number: _____

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CONSENT FOR TREATMENT

I, _____, client, legal guardian, give my consent to Oliver's Contracting, Consulting, and Counseling Services, PLLC to authorize substance abuse, mental health treatment, case management, and other treatment in the scope of the counselor's practice. I acknowledge that this service is voluntary and may discontinue services at any time at the request of the counselor with referral or myself.

I understand and agree that anticipated outcomes of treatment are possible in any facility or treatment setting. While Oliver's Contracting, Consulting, and Counseling Services, PLLC makes every effort to insure consumer safety and avoid unanticipated outcomes there; there are risk involved in substance abuse and mental health treatment. Unanticipated outcome includes, but not limited to, suicide or consumer major permanent loss of function and death.

Cost: The services provided by Oliver's Contracting, Consulting, & Counseling Services, PLLC are based on client's ability to pay, insurance, or Medicaid. As agreed upon, client will pay _____ at the time of service. The client has been authorized _____ number of sessions at this current rate, self-pay. Afterward, Client and Counselor will discuss additional sessions, referral, and/or aftercare/discharge.

Confidentiality: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand my records are protected, in regards, of the protection of HIV/AIDS information under G.S. 130 A-143.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Oliver's Contracting, Consulting, & Counseling Services, PLLC will follow the guidelines set forth in the NOTICE of PRIVACY PRACTICES. As indicated in the NOTICE of PRIVACY PRACTICES, Oliver's Contracting, Consulting, & Counseling Services, PLLC will not share any Protected Health Information regarding your involvement in treatment without prior knowledge and explicit written consent. The exception to this is a court order, the specific instances identified in the NOTICE of PRIVACY PRACTICES, or the following situations that are mandated by both Federal and State law based on the professional judgment of the counselor:

- **Threat of serious harm of self or others**
- **Suspected child or elder abuse or neglect**
- **A medical emergency**

I have read this information and understand its contents.

Name of Client (Please Print)

Witness

Client's Signature

Date

Parent's Signature (For clients under 18 years of age)

I have been provided with Oliver's Contracting, Consulting, & Counseling Services' Notice of Privacy Practices

Client's Signature

Date

Client Name: _____

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Attendance Agreement-Update

I understand that, in order for OliverCCCS to provide safe and effective treatment, I must keep regularly scheduled appointments. If I need to cancel, it should be only when it is urgent and unavoidable; under those circumstances, I should attempt to give at least 24 hours' notice. I understand that such need to cancel would be rare.

I therefore agree to keep all appointments that I make and not to miss appointments unless urgent and unavoidable. I will keep appointments at the frequency advised by this clinician.

I understand that if I do not honor this commitment and two (2) missed appointments of NO SHOW and/NO CALL; OliverCCCS will not be held responsible/liable for my care and will put my treatment on hold and/or up to terminate my treatment. I understand that I would be welcome to return when I could set and keep regular appointments. Additionally, in cases of mandated treatment, OliverCCCS will contact Department of Social Services (or other referral source) and alert the appropriate person of the missed sessions.

Cancellation and No Show/No Call Policy Acknowledgement & Preferred Means of Contact

I understand that if I do not provide **24-hour notice** prior to canceling an appointment or do not show for an appointment, I will be billed a **\$45.00** missed appointment fee. I understand that the missed appointment fee will be due at the next session. Additionally, if I miss 2 appointments my case may be terminated at the discretion of my assigned therapist. **Please note: The cancellation fee does not apply to EAP clients or Medicaid/Medicare members. For EAP clients, the appointments would be terminated.**

Please check below at least two preferred means of communication for receiving information (i.e., appointment confirmation, emergency cancellation, etc.). Information sent by email is not secured and confidentiality cannot be guaranteed.

Telephone/text – include number _____

*** Will leave a voicemail or text message:**

Email – list email address _____

US Mail – list address: _____

Other (including fax): _____

Signature of client or legal guardian _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

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CLIENT RIGHTS

Every program participant at Oliver's Contracting, Consulting, and Counseling Services, PLLC has human/civil/personal rights to be respected and honored. In addition, it is the responsibility of all program participants to act on a manner that respects the rights of others. Oliver's Contracting, Consulting, and Counseling Services, PLLC is committed to the protection of individual rights and to providing service within an environment that is characterized by dignity and respect of all people, and is responsive to the unique needs, abilities, and characteristics of each person served by the organization.

An individual shall at all times retain the right to:

- Make wishes about future treatment known.
- Confidentiality (as spelled out in Policy, a copy of which is available upon request).
- Be informed of the qualifications of the professionals rendering services
- Exercise all civic rights.
- A copy of an individualized, written program/service plan which includes the anticipated goals, as well as services to be provided in order to achieve these goals will be provided.
- Be free from physical punishment and unnecessary or excessive medication.
- Refuse medications.
- Be informed of experimental or nonstandard forms of service.
- Expect reasonable continuity of care, i.e. to know in advance, what appointment times and clinicians are available and where.
- Be free from influences in my decision of services and providers.
- Be informed of cost of service.
- Be considered of estimated length of service.
- Be considered legally competent unless there has been a court decision of incompetency.
- Refuse service or institute due process to terminate relations with **OLIVER'S CONTRACTING, CONSULTING, AND COUNSELING SERVICES, PLLC** free from searches or personal belongings except under critical circumstances.
- Expect special instructions and other requests to be honored when possible.
- I understand that I can contact Disability Rights North Carolina
3724 National Dr. #100,
Raleigh, NC 27608
(919) 856-2195 or (877) 235-4210 Fax (919) 856-2244
Website: www.cladisabilitylaw.org
Email: Info@disabilityrightsncc.org
- I understand that my treatment records will be stored electronically as well as a physical chart.



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For further clarification of rights, I will ask my **OLIVER'S CONTRACTING, CONSULTING, AND COUNSELING SERVICES, PLLC** Clinician/Therapist/Qualified Professional. As a client, I am aware that I have the right to request a different clinician/therapist/case manager at any time. I need to discuss this with my clinician/therapist/case manager or the Executive Director. For questions about availability of another provider in the network call 1-800-898-5898. If I believe that my rights may have been violated, I can file a grievance and appeal, if I am not satisfied with the resolution. Any of **OLIVER'S CONTRACTING, CONSULTING, AND COUNSELING SERVICES, PLLC** employees may assist me in doing this.

The above rights have been read by me or to me and explained to me by a member of **OLIVER'S CONTRACTING, CONSULTING, AND COUNSELING SERVICES, PLLC**.

This Consent expires on: _____

Consumer Signature

Date

Oliver's CCCS, PLLC Representative

Date

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Every time a patient sees a doctor or healthcare related person, a record is made of that person's confidential health information. In the past, these records were physically sealed away in offices and file cabinets. In an attempt to save the health care industry money, HIPPA was enacted which encouraged electronic transactions. Consequently, new safeguards were required to protect the security and confidentiality of personal health information, as private information was no longer simply locked in a file cabinet. These safeguards are referred to as the Privacy Rule.

The HIPPA federal regulation created national standards to protect individuals' personal health information, and gives patients increased access to their own medical records. Protected health information is any and all individually identifiable health information (information that can be linked to a client) that is transmitted or maintained by a health care provider regardless of the form of that information (i.e. oral, written, audio tape, video tape, computerized, etc.) This information includes, but is not limited to, an individual's past, present, and future health, health care, payment for health care, including demographic data, medical and psychological diagnoses and histories, medications, school records, financial records, etc. There are five basic principles outlined in the Privacy Rule: It gives patients more control over their health information It sets boundaries on the use and release of health records It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information. It holds violators accountable with civil and criminal penalties that can be imposed if they violate patients' privacy rights. It strikes a balance when public responsibility requires disclosure of some forms of data – for example, to protect public health.

What does this mean for everyday practice? In many ways, it is business as usual for OLIVERCCCS providers. It requires that we: Obtain written authorization to release information about clients to other health professionals, or parties involved with a client's wellbeing. Provide clients with written information (Notice of Privacy Practices) on their privacy rights and how their information may potentially be used. Be more conscientious of incidental use and disclosure of our client's person information (i.e. talking about client's personal information in a manner that cannot be overheard by others, ensuring that client information is kept secure in the office, that computers have passwords so that unintended users do not gain access to OLIVERCCCS client information). Ensure that when disclosure is appropriate and authorized, that information be limited to the amount of information reasonably necessary to accomplish the purpose for which disclosure is sought – i.e. do not provide more information than is necessary for the situation. Ensure that staff is limited to what is necessary to perform their specific job responsibilities. Ensure that only authorized staff including the Clinical Director, your therapist and the designated Client Care Coordinator have access to client records.

All OliverCCCS Staff, upon employment are trained in human rights and confidentiality and are required to sign a statement indicating that they have received and understand this training and that they agree to uphold the confidentiality of persons served. Minimize access to information

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by locking confidential files in filing cabinets in locked record rooms, by creating passwords on computers that maintain personal information and prohibit unauthorized transport of records. When transport of records is required, records are kept in a locked trunk during transport. Limit personal use and respecting the ownership of computers/software and other property of OLIVERCCCS. The Privacy Rule also has many guidelines for electronic transactions and code set standards, as well as guidelines for marketing, fundraising, research, and other activities in which AFS does not participate.

Consumer Signature

Date

Oliver's CCCS, PLLC Representative

Date

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**Notice of Privacy Practices/Disclosure Statement UNDERSTANDING YOUR HEALTH
RECORD/INFORMATION:**

As a client of OLIVERCCCS , a record of your health information is made. This record contains information including, but not limited to, any diagnoses, related symptoms, assessment and test results, treatment plans/goals, and eligibility information. This information, often referred to as your client record, serves as a basis for planning your care and treatment, and serves as a means of communication among the professionals on your treatment team who contribute to your care. Understanding what is in your record and how your health information is used to help ensure its accuracy, to better understand who, what, when, where and why others may utilize your health information, and helps you make more informed decisions when authorizing disclosure to others. North Carolina Statues (A PSM 45-1) and Federal confidentiality rules (Health Insurance Portability and Accountability Act of 1996, Public Law 104-191) require that written consent be given by the client, or legally responsible party, when disclosing confidential information. However, regarding releasing information without a client's consent, NC Statue (ASPM 45-1) states the following: "An agency that maintains client information shall give written notice to the client or client representative that disclosure may be made of pertinent information without his/her expressed authorizations in situations in which disclosure is in the best interest of the client or interest of public safety." While people are receiving supports and services from OliverCCCS PLLC there may be certain circumstances in which client's confidential information may be shared without consent. This rarely occurs and would only occur in accordance with NC General Statue 122C-52-56, and only in unusual circumstances including: 1. Sharing information with the persons next of kin if it is determined that it is in their best interest; 2. Sharing information with advocates when it is determined that it is in the persons best interest; 3. Sharing information with law enforcement under certain circumstances and attorneys in certain court proceedings in accordance with NC General Statue 122C-54; 4. Sharing information to report child or adult abuse or neglect situations, and other situations involving abuse, neglect, or domestic violence. 5. Sharing information with the Food and Drug Administration, governmental functions (such as national security) and agencies administering public benefits; 6. Sharing information with a health oversight agency; 7. Sharing information with medical examiners, coroners, funeral directors or for organ donation purposes; 8. Sharing information in the case of imminent danger to a person served where their health or safety or the health or safety of another individual is in danger, or if there is a likelihood of a person served or someone else in their life committing a felony or violent misdemeanor; 9. Sharing information with a public health authority, a physician or other health care provider who is providing emergency medical services to a person served to the extent necessary to meet the emergency; and 10. Sharing information for certain required reporting. In the event that OliverCCCS PLLC has to share confidential information about a person served without consent OliverCCCS PLLC will explain the action and the circumstances to the person served or to someone who is legally responsible for that person as soon as possible. OliverCCCS PLLC will also document it in your service record.

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YOUR HEALTH INFORMATION RIGHTS: Although your health record is a physical property of OLIVERCCCS, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, via the Director/DESIGNEE of OLIVERCCCS is not required to agree to a requested restriction). This includes the right to obtain a paper copy of confidentiality policies upon request; to inspect and obtain a copy of your client record upon request; to obtain an account of disclosures of your health information; to request communications of your health information by alternative means or at alternative locations; to revoke your authorization to use or disclose health information except to the extent that action has already been taken. **OUR RESPONSIBILITIES:** OLIVERCCCS is required to maintain the privacy of your health information, and if requested, to provide you with a notice as to our legal duties and confidentiality practices with respect to information we collect and maintain about you. OLIVERCCCS is obligated by law to abide by the terms of this notice, to accommodate reasonable requests you may have to communicate client information by alternative means or at alternative locations, and to notify you if we are unable to agree to a requested restriction. OLIVERCCCS reserves the right to change confidentiality practices and to make subsequent new provisions effective for all confidential information we maintain. Should such practices changes, you will be notified. OLIVERCCCS will not use or disclose confidential information without your authorization, except as described in this notice. If you have questions or concerns, contact the State Director. If you believe your confidentiality rights have been violated, you can file a written complaint with the State Director. 4108 Park Rd Ste. 408 Charlotte, NC 28209 Email: olivercccs@gmail.com I acknowledge that I have read and understand OLIVERCCCS'S policy regarding disclosure of confidential information, and have been informed verbally and in writing of the stipulations regarding disclosure without written consent as detailed in General Statutes 122C-52 through 122C-56. I acknowledge that any questions I have regarding this policy have been answered to my satisfaction prior to signing this notification of privacy practices.



Oliver's Contracting, Consulting, and Counseling Services, PLLC

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of **OLIVER'S CONTRACTING, CONSULTING, AND COUNSELING SERVICES, PLLC** Notice of Privacy Practices.

This Consent expires on: _____

Consumer Signature

Date

Oliver's CCCS, PLLC Representative

Date

CONSUMER CHOICE

I understand that there are other agencies within my local area that provides the services that **Oliver's Contracting, Consulting, and Counseling Services, PLLC** provides. I elect to pursue evaluation and/or treatment with Oliver's Contracting, Consulting, and Counseling Services, PLLC at this time. I further understand that if I choose to terminate my services with Oliver's Contracting, Consulting, and Counseling Services, PLLC I can do so without fear of coercion and/or retribution by the agency.

This Consent expires on: _____

Consumer Signature

Date

Oliver's CCCS, PLLC Representative

Date

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Permission for Evaluation and Emergency Care

I give consent to evaluation and/or treatment by Oliver's Contracting, Consulting, and Counseling Services, PLLC. I understand that this evaluation/treatment may include the referral to a psychiatrist for a psychiatric interview and/or monitoring of medications, referral to a psychologist for psychological testing, individual, family, or group counseling, mentoring or community support services. I reserve the right to withdraw this consent at any time. In addition, I reserve the right to refuse, at any time, any services or treatment offered.

Should it be determined that further evaluation and/or treatment is necessary and that available services are not appropriate, I understand that a referral may be made to me for a more appropriate service resource. I further understand that I may withdraw from the services at Oliver's Contracting, Consulting, and Counseling Services, PLLC at any time.

I grant permission for the service providers of Oliver's Contracting, Consulting, and Counseling Services, PLLC to treat minor medical emergencies that require first aid procedures as necessary. I also give my permission for Oliver's Contracting, Consulting, and Counseling Services, PLLC service providers to seek emergency medical care and emergency psychiatric care in the event that a medical emergency should occur. I understand that Oliver's Contracting, Consulting, and Counseling Services, PLLC staff will seek emergency care at the nearest hospital emergency room. I understand that I am responsible for any financial liability incurred as a result of any medical treatment that may be provided to the consumer.

I authorize Oliver's Contracting, Consulting, and Counseling Services, PLLC to contact the individual and /or physician I have listed on my emergency contact list in the event I become incapacitated due to emergency illness or accident while in treatment. This emergency contact consent will be in lieu of any other authorizations, if any, I have granted or not granted to illness or accident while in treatment to the individual listed on my emergency contact form.

I also hold harmless Oliver's Contracting, Consulting, and Counseling Services, PLLC against any liability caused by their taking of any emergency procedures and/or contacts. I agree to the Emergency Care Process as outlined above. I will also take full responsibility of all incurred treatment expenses.

This release shall remain valid until revoked in writing by me. Such revocation will not affect any treatment or intervention that may have been provided prior to the revocation of consent.

I have read the above statements and have received clarification from a member of Oliver's Contracting, Consulting, and Counseling Services, PLLC staff for any item that I do not understand.

Consumer Signature

Date

Oliver's CCCS, PLLC Representative

Date

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Outpatient MH/SS/DD Service Agreement and Consent

It is important that you understand the kinds of services you will be provided and the terms and conditions in which the service will be offered. I am requesting treatment from the staff of the condition of Oliver's Contracting, Consulting, and Counseling Services, PLLC. As a condition of that treatment, I acknowledge the following items and agree to them.

I understand:

_____1. The staff believes that the outpatient treatment strategies the program uses to provide useful intervention or chemical dependency problem; however, no specific outcome can be guaranteed.

_____2. Treatment participation requires some basic rules. These conditions are essential for a successful treatment experience. Violation of these rules can result in treatment termination.

I agree to the following:

- A. It is necessary to arrive for appointment on time. At each visit I will be prepared to take urine in breath-alcohol test.
- B. Conditions of treatment required abstinence in it from all drugs and alcohol use for the entire duration of the treatment program. If I am unable to make this commitment, I will discuss other treatment program. If I am unable to make this commitment, I will discuss other treatment options with the program staff.
- C. I will discuss any drug or alcohol use with the staff and the group while in treatment.
- D. Treatment consists of individual and group sessions. Individual appointments can be rescheduled, if necessary. I understand that group appointments cannot be rescheduled and that attendance is extremely important. I will notify the counselor in advance if I am going to miss a group session. Telephone notification may be made for last minute absences or lateness.
- E. Treatment will be terminated if I attempt to sell drugs on courage drug use of any other clients.
- F. I understand that graphic stories of drug or alcohol use will not be allowed.
- G. I agree not to become romantically or sexually involved with other clients.
- H. I understand it is not advisable to be involved in any business transactions with other clients.
- I. I understand that all matters discussed in group sessions and the identities of all other members are absolutely confidential. I will not share this information with non-members.
- J. All treatment is voluntary. If I decide to terminate treatment, I will discuss this decision with the staff.

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_____ 3. Staff services are provided by psychologists, license marriage and family counselors, master's-level counselors-in-training, or other certified addiction staff people. All non-licensed counselors are supervised by a licensed counselor trained in the treatment of addictions.

_____ 4. Confidentiality: All information disclosed in these sessions is strictly confidential and may not be revealed to anyone outside the program staff without the written permission of the client or client's family. The only exceptions are when disclosures are required or permitted by law. Those situations typically involve a substantial risk of physical harm to oneself or others or suspected abuse in children and the elderly.

_____ 5. Accomplishing treatment goes require cooperation and active participation of clients and the families. Very rarely, lack of cooperation by client may interfere substantially with the program for ability to render services effectively to the client or to others. Under such circumstances, the program may discontinue services to the client.

_____ 6. I consent to transportation by OliverCCCS staff and agree to hold OliverCCCS and its staff members harmless from any liability that results from the provision for transportation. I also consent to emergency medical treatment in the event that I am unable to provide such consent in an emergency.

I certify that I have ready, understand, and accept this Service Agreement and Consent, This agreement and consent cover the length of time I am involved in treatment activities with Oliver's Contracting, Consulting, and Counseling Services, PLLC.

Consumer Signature

Date

Oliver's CCCS, PLLC Representative

Date

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Acknowledgment of Client Grievance Process

Purpose of the Client Grievance Process

Oliver's Contracting, Consulting, and Counseling Services, PLLC fully trains staff to be compassionate and attentive to the concerns of the persons served, which results in a comfort level being established that allows person served to openly communicate and pursue resolutions through the information and channels that are available to them. It is our responsibility to ensure that each person served is afforded due process regarding rights and services. Being fully informed regarding their rights will assist persons served with needs to file a complaint or grievance should it become apparent.

Policy for the Client Grievance Process

It is the policy of Oliver's Contracting, Consulting, and Counseling Services, PLLC to encourage person served to state complaints and /or grievances if they believe their rights have been violated, and to pursue resolutions to their concerns in a structured format that provided fair and equitable results through due process.

- A. Persons served will be fully informed of the grievance process during their orientation to services and receive printed materials for later reference. (Clients must sign a Receipt of Client Grievance Process form, which will be filed in their client file)
- B. Day-to-Day issues affecting the person served shall be resolved informally between the person served and the primary staff member responsible for his/her service coordination.
- C. Persons served have the right to due process with regard to grievance and the organization will afford every reasonable opportunity for informal and/or formal resolutions of the grievance.
- D. Persons who may bring grievance include, but are not limited to :
 - 1. The person served
 - 2. The guardian of the person served.
 - 3. The attorney, designated representative, or a representative of a rights protection or advocacy agency of the person served.
 - 4. A grievant shall in no way be subject to disciplinary action or reprisal, including reprisal in the form of denial or termination of services, loss of privileges, or loss of services as a result of filing a grievance.

Your Rights to a Formal Client Grievance

During a formal grievance procedure, you have the right to the following:

- A. Assistance by a representative of your choice.
- B. Review of information obtained in processing the grievance, except that which would violate the confidentiality of another person served.
- C. Presentation of evidence of witnesses pertinent to the grievance.
- D. Receipt of complete findings and recommendation, except those that would violate confidentiality of another person served.

Steps to Filing a Formal Client Grievance

Step One: Formal Grievance shall be filed first with the Program Manager of the agency; using the **Compliant or Grievance Form** or the complainant may contact the **Clinical Director**.

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Step Two: The Clinical Director of Programs will meet with you, the grievant, and/or representatives, immediately following the filing to brainstorm resolution of any related issues that may get in the way of full participation in services. Actions may include, but not limited to, a change in direct care providers or an adjustment in programming scheduled and/or program environments.

Step Three: The Clinical Director of Programs will issue a formal written response to you, the grievant, and/or the designated representative, within five working days of receiving the complaint, excluding weekends or holidays, of the complaint.

How to Appeal a Formal Written Response

Step One: If you, the grievant, is unsatisfied with the findings of the written response to a grievance, he or she may appeal the decision to the **Executive Administrator** within five days excluding weekends or holidays.

Step Two: The **Executive Administrator** will issue a formal written response to the grievant, and/or the designated representatives, within five working days excluding weekend or holidays, receiving the complaint.

Step Three: If you, the grievant, is unsatisfied with the finding of the written response, he/she will be referred to the Client Rights Committee. The Client Rights Committee will issue a formal written response to you, the grievant, within five working days, excluding weekends or holidays, of receiving the complaint.

Note: The Client Rights Committee is the last appeal process in the agency. You will be informed of any external appeal process that is open to you if they are not satisfied with the recommendations of the Clients Rights Committee.

Escalation to the Corporate Compliance Specialist

In the event that a complaint is formally reported to the **Executive Administrator** via the agency's hotline, the **Executive Administrator** will make contact with the complainant to assist in mediating a resolution in collaboration with the Director of Programs.

The **Executive Administrator** can be contacted at **704-942-0593**

Acknowledgement of Client Grievance Process

I have been fully informed of my rights to file a Client Grievance Process at Oliver's Contracting, Consulting, and Counseling Services, PLLC. Further, I fully understand that formal process of file an appeal a complaint or grievance should the need become apparent.

Consumer Signature

Date

Oliver's CCCS, PLLC Representative

Date

Oliver's CCCS, PLLC 4108 Park Rd. Suite 408

Charlotte, 28209

704-777-4525

Updated 05/28/24

Client Name:

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Acknowledgment of Suspension/Expulsion Policy

It is the policy of Oliver's Contracting, Consulting, and Counseling Services, PLLC to work with a client until all means have been exhausted. Under the following conditions, Oliver's Contracting, Consulting, and Counseling Services, PLLC may expel or suspend a client from treatment:

- Refusal of treatment for a period of ten consecutive days (unless extenuating circumstances apply);
- The client becomes a threat to themselves or others
- Destruction of facility property;
- Threatening and/or assaulting, verbally or physically, any staff member;

Clients will be suspended until a meeting with the Treatment Team is held to discuss matters thoroughly. Upon satisfactory completion of a meeting and agreement among all parties, a mutually agreed upon timeline, and conditions (if possible) services for the client will resume. The Qualified Professional or designee will be responsible for notifying all parties of this meeting. In the event that services cannot be reinstated, Oliver's Contracting, Consulting, and Counseling Services, PLLC will assist client in choosing another treatment option that better suits their needs.

By signing this form I acknowledge that I have been fully informed of Oliver's Contracting, Consulting, and Counseling Services, PLLC Suspension and Expulsion policy.

Consumer Signature

Date

Oliver's CCCS, PLLC Representative

Date

Client Name:

DOB:

Insurance #

Acknowledgment of Search and seizure practices

Oliver's Contracting, Consulting, and Counseling Services, PLLC reserves the right to use **search and seizure practices** for clients when current or past behaviors warrant the use of this practice.

- Clients may be required to deposit all backpacks, purses, and any other objects that can conceal weapons or other inappropriate objects in a designated room at the agency. Staff has the right to search the contents of these objects in the presence of another staff member.
- Clients may be required to empty the contents of all of their pockets in front of 2 staff persons to assure that no inappropriate objects are present. Anything that is determined to be a hazardous or inappropriate will be confiscated and a staff person will contact the authorities or client's parent or guardian to report the inappropriate findings. If the content is not determined to be dangerous or hazardous, the items will be returned to the client or guardian when they leave the agency.
- Use of strip searches is strictly prohibited.
- If a search produces any concealed weapons or illegal drugs, the Executive Administrator will be notified immediately and the proper authorities will be called. An incident report and search and seizure form will be completed within (24) hours of the incident.
- Search and seizure reporting must include:
 - Scope of Search
 - Reason for Search
 - Procedures followed in the Search
 - Description of any property seized
 - Account of the disposition of seized property

I acknowledge that I have been read and understand Oliver's Contracting, Consulting, and Counseling Services, PLLC, client search and seizure policy.

Consumer Signature

Date

Oliver's CCCS, PLLC Representative

Date

Client Name:

DOB:

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Receipt of Client Information

I acknowledge that I have received a copy of the Oliver's Contracting, Consulting, and Counseling Services, PLLC Client Rights Handout and have been informed of the rights to which I am entitled as a recipient of services provided by this agency. I understand that I may contact persons associated with this company and/ or the Governor's Advocacy Council for Persons with Disabilities.

Additionally, I have received a copy of the Oliver's Contracting, Consulting, and Counseling Services, PLLC Grievance Procedure and additional information regarding client rights. I understand the process to make a complaint and have been provided the telephone number to LME.

Initial upon receipt of:

_____ Agency Rules and Regulations

_____ Your Rights as a Client

_____ Notice of Privacy Practices

_____ Client Rights Handout

_____ HIPPA Regulations

Consumer Signature

Date

Oliver's CCCS PLLC Representative

Date

Client Name:

DOB:

Insurance #

My Private Practice Social Media Policy: Please initial each session

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

____ **Friending:** I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

____ **Facebook:** I keep a private Facebook page. I will not friend any current or former clients on any social networking site. I believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list. In addition, the American Psychological Association's Ethics Code prohibits my soliciting testimonials from clients. I feel that the term "Fan" comes too close to an implied request for a public endorsement of my practice.

____ **Our working relationship:** My primary concern is your privacy. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

____ **Interacting:** Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

____ **Important to know:** Oliver's Contracting, Consulting, & Counseling Services' representative(s) will contact you by calling or texting to confirm, change, cancel, or follow up as needed, in response to a call or text. If you need to contact me between sessions, the best way to do so is by calling on the phone or texting. You can use this for administrative issues such as changing appointment times, confirming appointment time, or sharing issues that may come up. I will contact you by a call or text for up to 15 minutes. After that you will need to come into the office. All calls and texts will be documented and placed in your file.

Client Name: _____

DOB: _____

Insurance # _____

_____ **Use of Search Engines:** It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

_____ **Google Reader:** I do not follow current or former clients on Google Reader and I do not use Google Reader to share articles. If there are things you want to share with me that you feel are relevant to your treatment whether they are news items or things you have created, I encourage you to bring these items of interest into our sessions.

_____ **Business Review Sites:** You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

_____ **Location-Based Services:** If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

_____ **Email:** I prefer not using email. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential.

If you choose to communicate with me by Social Media Policy: Janet Oliver White, 4108 Park Rd. Ste. 408, Charlotte, NC 28209, 704-777-4525, www.psychologytoday.com: Janet O White Email: olivercccs@gmail.com, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Conclusion: Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

Client signature: _____ Date _____

OCCCS Rep. Signature: _____ Date _____



Client Name:

DOB:

Insurance #

After Hours Calls

I, _____, understand that there are other agencies with my local area that provides the services that Oliver's Contracting, Consulting, and Counseling Services, PLLC provides. I also understand that if I am unable to reach a staff from Oliver's Contracting Consulting, and Counseling Services, PLLC< non-emergency, I can contact _____. If it is an emergency, I understand to call mobile crisis Line at 704-566-3410 or dial 911.

This consent expires on: _____

Consumer Signature

Date

Oliver' CCCS, PLLC Rep.

Date

Client Name:

DOB:

Insurance #

ACCOUNTING OF RELEASE/DISCLOSURE OF CLIENT INFORMATION

NOTICE TO CLIENT/GUARDIAN: Release/disclosure policy of pertinent information in the client record has been explained and/or is available to the client/guardian in writing.

Date	Information Released/Disclosed (What, Recipient, Method & Purpose)	Signature