Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic
Application Assessment

Child's Full Name:_____
Date of Birth:_____Race:_____Gender: Male or Female
Social Security Number:_____

Mother's Name:_____Date of Birth:_____
Father's Name:_____Date of Birth:_____
Is the child adopted: Yes No If Yes: Age when child was adopted? _____
Is the child involved in Foster Care System: Yes No
If Yes when did placement start? _____
Name and address of person with whom the child resides (include street, city and zip code):_____
_____
Home phone number:_____
Parents:) circle one) Married Unmarried Separated Divorced Widowed
Who has legal custody of child?_____

Please list all persons living in child's home and their date of birth:
_____
_____
_____
_____

Mother's occupation:_____Mother's work phone:_____
Mother's employer:_____ Annual Salary _____
Highest school grade completed:_____

Father's occupation:_____Father's work phone:_____
Father's employer:_____ Annual Salary _____
Highest school grade completed:_____

Birth/Medical History
Were there problems during the pregnancy, labor, or delivery? If so, explain:_____
How many weeks or months was the pregnancy?_____Baby's birth weight:_____
Birth was:(please ircle) Normal Cesarea Breech Twins or more
Did baby have problems after birth?_____If yes, please explain:_____
_____
Please list any major illnesses or injuries your child has had to this date:_____
Is your child taking any medications regularly? If yes please list below:
_____

(over)

Developmental History

At what age did your child: Roll over_____ Sit Alone_____
Pull up to furniture_____Crawl_____Walk_____
Say single words_____Say 3 word sentences_____
Become toilet trained_____

Referral Concerns

What are your primary concerns about your child?

_____

_____

What have you been told regarding these concerns? (by your child's doctor, etc..)

_____

Has your child received a behavioral or medical diagnosis? If yes please note:

_____

Who referred you to the Therapeutic Day Program Outpatient Therapy Clinic?_____

Please check the areas that you have current concerns about your child:

Picking up small objects	Toilet training
Walking	Running
Climbing (play equipment/stairs)	Using a crayon/pencil
Jumping	Using scissors
Following simple directions	Combining words into phrases
Understanding what you say	Speech being understood by others
Awareness of others	Interest in imitating others
Seeking out others to play	Enjoying simple interactions game
Using eye-contact appropriately	
Taking turns during play with others	Responding to affection
Attention span	Not obeying
Ability to remain in seat when needed	Temper tantrums
Being always on the go	Talking back
Sleep problems	
Hitting, biting, or kicking peers or siblings	
Hitting, biting, or kicking parent/legal guardian	
Physical growth	Learning what has been taught
Eating skills (i.e., chewing, swallowing)	Remembering things
Unusual food preferences	Vision
Lack of eating	Hearing
Other:	

Pre-school/School History

Does your child attend daycare, preschool, or school? If yes, list name and address of program and how long has child been enrolled:

Has the child received a developmental evaluation? (If yes, who performed the evaluation?

Does child receive any special therapies or services (i.e., speech therapy, early intervention, other)? If so explain:

Does you child have an IEP? Yes No
(If your child has an IEP kindly provide the program a copy of the plan)

Do you think your child needs additional services? If so explain:

What would you like to see accomplished for your child through counseling?

Please complete the following to assist us in obtaining information needed to plan for your child's treatment

Child's current doctor and address

Pleas list any other doctors/evaluators who have treated your child and their addresses:

Has your child ever been an inpatient or outpatient at NC Baptist Hospital or Brenner Children's Hospital (If so explain):

(over)

Name of person completing this form:_____

I do hereby give my permission as this child's parent or guardian to have him/her treated/evaluated by the Therapeutic Day Program Outpatient Clinic. I understand that this facility is both a service and a training program, and give my consent to have fully supervised students participate in the evaluation.

Parent/Guardian
Signature:_____Date:_____

Kindly fax or mail this form once complete:
Attention: TDP Program Assistant
Fax to (336) 765-0842
Address: 3325 Silas Creek Pkwy
Winston-Salem, NC 27103

Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic
3325 Silas Creek Parkway
Winston-Salem, NC 27103

Financial Coverage

(Please Complete)

Client's Name _____ Birth date: _____

Social Security Number: _____

Is client covered by any **private insurance**? Yes No

Policy #1:
Policyholders Name: _____

Employer: _____

Name of Insurance Company: _____

Address and Telephone Number: _____

Policy Number: _____ I.D. number: _____
Group Number: _____
Claims Address: _____

Policy #2:
Policyholders Name: _____

Employer: _____

Name of Insurance Company: _____

Address and Telephone Number: _____

Policy Number: _____ I.D. number: _____
Group Number: _____
Claims Address: _____

Is client covered by **Medicaid**? Yes No Is client covered by **NC HealthChoice**? Yes No

Medicaid Number: _____ NCHealthChoice number: _____

Mail To:
Amos Cottage Therapeutic Day Program
Attention: TDP Program Assistant
3325 Silas Creek Parkway
Winston-Salem, NC 27103

Is client approved for outpatient services? Yes No

Carolina Access Doctor's Name: _____

Doctor's Carolina Access number (contact PCP to obtain number): _____

WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center CareNet, Inc.)

For Office Use Only MRN _____
Date Rec'd _____ Date Sent _____
Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(Patient name & date of birth)

To be Released From/By: - _____ *(Primary Care Provider)*
(Name of Entity, Person(s) or class of persons authorized to receive the information)

_____
(Address of authorized recipient of information)

To be Released to: *Amos Cottage Therapeutic Day Program Outpatient Program*
(Name of Entity, Person(s) or class of persons authorized to receive the information)

3325 Silas Creek Parkway, Winston Salem, NC 27103, (336) 713-7444, phone, (336) 765-0842, fax
(Address of authorized recipient of information)

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

☐ Emergency Department	☐ Radiology result	☐ Clinical	☐ Evaluations
☐ Discharge Summary	☐ Cardiac Catheterization	☐ Mental Health Impressions	☐ Visit History
☐ History & Physical	☐ Pathology report	☐ Previous Referrals	☐ Verbal Exchange
☐ Operative Report	☐ Lab result	☐ Testing	☐ Treatment Plan
☐ Office/Clinic Note	☐ Reason for Referral	☐ Diagnostic/treatment records	☐ Other – Please specify: _____

☐ Entire visit (provider notes, results, flow sheets/nursing notes, scanned documents, etc.)
☐ any other pertinent information to support Day Treatment Program Admission and Treatment

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range ☐ _birth_____ to ___ongoing_____

Please provide the **treatment location** (specific hospital, or physician practice location, department):
Amos Cottage Therapeutic Day Program, 3325 Silas Creek Parkway, Winston Salem, NC 27103 (336) 713-7444-p, (336) 765-0842-f

The information will be used/disclosed for the following **purpose:**
☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ paper copy ☐ CD ☐ Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: ☐pickup, ☐ Paper Copy ☐ CD ☐ MyChart ☐ Other:
for the periods from _____ through _____

I understand that if the person(s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

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_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient ***(written proof may be required)***

This release is limited to the Facility/Practice or Department you specified above.
To obtain information from another Facility/Practice or Department individual authorizations will be needed.

MRROI

WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center CareNet, Inc.)

For Office Use Only MRN _____
Date Rec'd _____ Date Sent _____
Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(Patient name & date of birth)

To be Released From/By: ***Amos Cottage Therapeutic Day Program Outpatient Clinic***
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

3325 Silas Creek Parkway, Winston Salem, NC 27103, (336) 713-7444, phone, (336) 765-0842, fax
(Address or location of Facility, Practice, Department who may use/disclose the information)

To be Released to: **(Primary Care Provider)**
(Name of Entity, Person(s) or class of persons authorized to receive the information)

_____
(Address of authorized recipient of information)

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

☐ Emergency Department	☐ Radiology result	☐ Clinical	☐ Evaluations
☐ Discharge Summary	☐ Cardiac Catheterization	☐ Mental Health Impressions	☐ Visit History
☐ History & Physical	☐ Pathology report	☐ Previous Referrals	☐ Verbal Exchange
☐ Operative Report	☐ Lab result	☐ Testing	☐ Treatment Plan
☐ Office/Clinic Note	☐ Reason for Referral	☐ Diagnostic/treatment records	☐ Other – Please specify: _____

☐ Entire visit (provider notes, results, flow sheets/nursing notes, scanned documents, etc.)
☐ any other pertinent information to support Day Treatment Program Admission and Treatment

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range ☐ birth _____ to ongoing

Please provide the **treatment location** (specific hospital, or physician practice location, department):
Amos Cottage Therapeutic Day Program, 3325 Silas Creek Parkway, Winston Salem, NC 27103 (336) 713-7444-p, (336) 765-0842-f

The information will be used/disclosed for the following **purpose:**
☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ paper copy ☐ CD ☐ Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: ☐ pickup, ☐ Paper Copy ☐ CD ☐ MyChart ☐ Other:
for the periods from _____ through _____

I understand that if the person(s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

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_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient ***(written proof may be required)***

This release is limited to the Facility/Practice or Department **you specified above.**
To obtain information from another Facility/Practice or Department individual authorizations will be needed.

MRROI

School Information Request
(To be completed by school or daycare staff)

Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic
Application Assessment
3325 Silas Creek Parkway
Winston-Salem, NC 27103
Telephone: (336) 713-7444
FAX: (336) 765-0842

Child's Name:_____

Dear Teacher:

The parent/legal guardians of the above named child are interested in receiving counseling services for their child at the Therapeutic Day Outpatient Clinic at Amos Cottage. Your responses to the following questions are an essential component to the evaluation for admission, and will be greatly appreciated.

A. Basic Information:

1. Name and Address of School: _____Phone:_____
2. Hours of attendance: _____Teacher:_____
3. Number of students on class: _____Age Range/Grade:_____
4. Number of adults (teachers, aides, volunteers) available for supervision of these children:_____
5. Does this child have an active IEP in place: (If the child has an IEP the program may request a copy)
6. Do you have any behavioral concerns at the present time Please include concerns regarding social & emotional functioning.
   1)_____
   2) _____
   3) _____
   4) _____

Kindly fax or mail this form once completed
Attention: Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic
Administrative Assistant
Fax to (336) 765-0842
Address: 3325 Silas Creek Pkwy
Winston-Salem, NC 27103

Comments:

Signature: _____
Title:_____
Date:_____

WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center CareNet, Inc.)

For Office Use Only MRN _____
Date Rec'd _____ Date Sent _____
Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(Patient name & date of birth)

To be Released From/By: ***Amos Cottage Therapeutic Day Program Outpatient Clinic***,
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

3325 Silas Creek Parkway Winston Salem, NC 27103, (336) 713-7444, phone, (336) 765-0842, fax
(Address of authorized recipient of information)

To be Released to: _____ ***(Daycare/School)***
(Name of Entity, Person(s) or class of persons authorized to receive the information)

_____
(Address of authorized recipient of information)

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

☐ Emergency Department	☐ Radiology result	☐ Clinical	☐ Evaluations
☐ Discharge Summary	☐ Cardiac Catheterization	☐ Mental Health Impressions	☐ Visit History
☐ History & Physical	☐ Pathology report	☐ Previous Referrals	☐ Verbal Exchange
☐ Operative Report	☐ Lab result	☐ Testing	☐ Treatment Plan
☐ Office/Clinic Note	☐ Reason for Referral	☐ Diagnostic/treatment records	☐ Other – Please specify: _____

☐ Entire visit (provider notes, results, flow sheets/nursing notes, scanned documents, etc.)
☐ any other pertinent information to support Day Treatment Program Admission and Treatment

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range ☐ _Birth_____ to _Ongoing_

Please provide the **treatment location** (specific hospital, or physician practice location, department):
Amos Cottage Therapeutic Day Program, 3325 Silas Creek Parkway, Winston Salem, NC 27103 (336) 713-7444-p, (336) 765-0842-f

The information will be used/disclosed for the following **purpose:**
☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ paper copy ☐ CD ☐ Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: ☐pickup, ☐ Paper Copy ☐ CD ☐ MyChart ☐ Other:
for the periods from _____ through _____

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_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient ***(written proof may be required)***

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WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center CareNet, Inc.)

For Office Use Only MRN _____
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Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(Patient name & date of birth)

To be Released From/By: _____ ***(School/Daycare)***
(Name of Entity, Person(s) or class of persons authorized to receive the information)

_____
(Address of authorized recipient of information)

To be Released to: ***Amos Cottage Therapeutic Day Program Outpatient Program***
(Name of Entity, Person(s) or class of persons authorized to receive the information)

3325 Silas Creek Parkway, Winston Salem, NC 27103, (336) 713-7444, phone, (336) 765-0842, fax
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

☐ Emergency Department	☐ Radiology result	☐ Clinical	☐ Evaluations
☐ Discharge Summary	☐ Cardiac Catheterization	☐ Mental Health Impressions	☐ Visit History
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☐ Office/Clinic Note	☐ Reason for Referral	☐ Diagnostic/treatment records	☐ Other – Please specify: _____

☐ Entire visit (provider notes, results, flow sheets/nursing notes, scanned documents, etc.)
☐ any other pertinent information to support Day Treatment Program Admission and Treatment

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range ☐ Birth to Ongoing

Please provide the **treatment location** (specific hospital, or physician practice location, department):
Amos Cottage Therapeutic Day Program, 3325 Silas Creek Parkway, Winston Salem, NC 27103 (336) 713-7444-p, (336) 765-0842-f

The information will be used/disclosed for the following **purpose:**
☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ paper copy ☐ CD ☐ Other_____ *(if not specified, records will be provided in paper form)*

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_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

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Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient ***(written proof may be required)***

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AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(Patient name & date of birth)

To be Released From/By: *Amos Cottage Therapeutic Day Program Outpatient Clinic*,
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

3325 Silas Creek Parkway Winston Salem, NC 27103, (336) 713-7444, phone, (336) 765-0842, fax
(Address of authorized recipient of information)

To be Released to: Winston Salem Forsyth County School System
(Name of Entity, Person(s) or class of persons authorized to receive the information)

P.O. Box 2513, Winston Salem, NC 27102, (336) 727-2816, phone
(Address of authorized recipient of information)

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and/or HIV/AIDS, if applicable.)*

Specific records:

☐ Emergency Department	☐ Radiology result	☐ Clinical	☐ Evaluations
☐ Discharge Summary	☐ Cardiac Catheterization	☐ Mental Health Impressions	☐ Visit History
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☐ any other pertinent information to support Day Treatment Program Admission and Treatment

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range ☐ birth to ongoing

Please provide the **treatment location** (specific hospital, or physician practice location, department):
Amos Cottage Therapeutic Day Program, 3325 Silas Creek Parkway, Winston Salem, NC 27103 (336) 713-7444-p, (336) 765-0842-f

The information will be used/disclosed for the following **purpose:**
☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ paper copy ☐ CD ☐ Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: ☐pickup, ☐ Paper Copy ☐ CD ☐ MyChart ☐ Other:
for the periods from _____ through _____

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_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient ***(written proof may be required)***

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MRROI

WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center CareNet, Inc.)

For Office Use Only: MRN _____
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Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(Patient name & date of birth)

To be Released From/By: Winston Salem/Forsyth County School System
(Name of Entity, Person(s) or class of persons authorized to receive the information)

P.O. Box 2513, Winston Salem, NC 27102, (336) 727-2816, Phone
(Address of authorized recipient of information)

To be Released to: ***Amos Cottage Therapeutic Day Program Outpatient Program*** ,
(Name of Entity, Person(s) or class of persons authorized to receive the information)

3325 Silas Creek Parkway, Winston Salem, NC 27103, (336) 713-7444, phone, (336) 765-0842, fax
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

☐ Emergency Department	☐ Radiology result	☐ Clinical	☐ Evaluations
☐ Discharge Summary	☐ Cardiac Catheterization	☐ Mental Health Impressions	☐ Visit History
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☐ Office/Clinic Note	☐ Reason for Referral	☐ Diagnostic/treatment records	☐ Other – Please specify: _____

☐ Entire visit (provider notes, results, flow sheets/nursing notes, scanned documents, etc.)
☐ any other pertinent information to support Day Treatment Program Admission and Treatment

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range ☐ birth _____ to ongoing _____

Please provide the **treatment location** (specific hospital, or physician practice location, department):
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The information will be used/disclosed for the following **purpose:**
☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ paper copy ☐ CD ☐ Other _____ *(if not specified, records will be provided in paper form)*

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I understand that if the person(s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

☐ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.

☐ I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken based on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires on _____. Unless a date of expiration is provided or this authorization is revoked, this authorization will expire one (1) year from the date signed.

_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient ***(written proof may be required)***

This release is limited to the Facility/Practice or Department **you specified above.**
To obtain information from another Facility/Practice or Department individual authorizations will be needed.

MRROI

Wake Forest™
Baptist Health
Brenner Children's Hospital

Dear Parents/Legal Guardian:

Thank you for choosing Wake Forest Baptist Health for your child's treatment. In order to make your treatment as successful as possible, please review our expectations of you and what you can expect of us.

Expectations of the Parents/Legal Guardians:

1. You are expected to come to all scheduled appointments and arrive early or on time. If you are unable for any reason to make your child's appointment, you are expected to call at least 24 hours in advance of your scheduled appointment. Please call Robin Powell, Administrative Assistant at (336) 713-7444.
2. Non compliance, such as two or more no shows or late cancellations in a 12 month period, excessive cancellations, not following through with treatment recommendations, or failure to make timely payments, may result in termination of services, and you will be referred to a mental health provider in the community.
3. You are expected to work with your provider in adhering to the treatment plan.
4. Payment is due at the time of service. If your treatment is authorized by your insurance plan, we will bill your insurance company directly. Deductable payments and co-payments are your responsibility and are required at the time of service. **If your insurance plan does not cover this level of service you will be responsible to pay the full session fee at the time of the appointment.**

Expectations of your Provider:

1. During week days, we will attempt to return all routine calls by the next business day. Regular weekday clinic hours are from 8:00am to 5:00pm. For emergencies on weekends, or when the clinic is closed, please call (336) 713-7400 and you will be directed to a specialized Pediatrician on call to receive consultation or you may call **911** and request assistance or you make take your child to the nearest emergency department.
2. We will work with you to develop a thorough treatment plan.
3. HIPPA (Health Insurance and Privacy and Protection Act) regulations protect the privacy of all communications between a patient and their mental health provider. The exceptions to this law include: 1) Dangerousness to self. 2) Dangerousness to others. 3) Suspicion of neglect, sexual or physical abuse of a child. Neglect and abuse are reported directly to the Department of Social Services which conducts its own investigation. It may also result in hospitalization. The clinician may during the course of treatment suggest a higher level of treatment if your child is at risk of harming themselves or others.
4. Request for your records will be reviewed by the provider. It is their professional judgment whether the information will be released as requested.
5. If for any reason it is determined that your child's counseling services should be discontinued, we will provide 30 days of care so that you can locate a new mental health provider. Upon written notification of termination of services, you will receive a release for medical records to sign and return. Records may be transferred to any new provider you may indicate after proper consent from you is received.

My signature below indicates that I have read and fully understand the above patient's services and agree to the specifications described therein:

_____	_____	_____	_____
Signature (or signature of Parent/Legal Guardian)	Date	Provider	Date