

## **SECTION IV**

### **❖ INTAKE PAPERWORK**

## CLIENT CONTRACT

### REQUIREMENTS FOR REINSTATEMENT OF YOUR DRIVERS LICENSE:

To have your license reinstated, you must obtain a certificate of completion.

A certificate of completion can be obtained by:

- A) Completing a substance abuse assessment at an authorized NC DWI Services provider
- B) Completing the recommended level of treatment or education at an authorized NC DWI Services provider.

### CLIENT CHOICE:

\* I understand that I have the right to choose to complete my recommended level of treatment or education at any authorized NC DWI Services provider. Here is a list of authorized NC DWI Services provider in this area from which I may choose to complete my recommended level of care:  
NC DWI Services 919-733-0566

### SERVICE LEVEL RECOMMENDATION:

Level: \_\_\_\_\_  
Minimum # of hours: \_\_\_\_\_  
Must be completed in a minimum of \_\_\_\_\_ days (Duration)

### ASSESSMENT POLICY:

\* I understand that my DWI substance abuse assessment is valued for 6 months. If I have not begun the recommended DWI treatment or education within 6 months from the assessment date a new assessment and assessment fee will be required. **EXPIRATION DATE** \_\_\_\_\_

### PROGRAM REQUIREMENTS AND FEES:

Should you choose to complete your recommended level of care at Insightful Options, PLLC listed below are the program requirements and fees:

- |  |   |
|--|---|
| A. DWI Substance Abuse Assessment for the purpose of obtaining a certificate of completion | \$100   |
| B. Payments to the ADETS School  | \$160.00  |
| C. Rate per hour for Program   | \$20.00 (i.e. 20 hour program equals \$400.00 and 40 hours \$800.00)                                |
| D. 12 Panel Urine Screen and lab results   | \$45.00 Random screening during treatment/\$85.00 for additional lab testing includes shipping cost |
| E. Substance Abuse/ Mental Health Assessment   | \$150.00  |
| F. Saliva Screening Fee  | \$15.00   |

Treatment classes must be attended weekly and if more than one week is missed a letter documenting dates must be provide to staff or email must be provided and sent to ( ) with date and time stamp proof. The notification must be sent and will be placed in clients chart as a notice of verification. If more than two weeks is missed the client agrees that treatment will have to start over with no refund and no credit. (If the client has a major emergency (work, family, etc...) then a letter must be provided to inform Clinical Director of the emergency; you, the client, will get a follow up response from Clinical Director with further follow up instructions) No treatment services will exceed 6 months to 1 year without appropriate documentation. In the event of any of the above circumstances and situations, the case will be staffed with NC DWI Office for further recommendations, if any. IO, PLLC recommendation will be to re-start the program from the beginning and pay the fee again. Payment of what is owed still applies.

\_\_\_\_ADETS Class- I understand that I will attend 5 days of classes and will be on time for each session. If there is an emergency and I can't complete the class sessions in sequential order, I understand I must restart the class on the days that I missed the next month with written documentation of the reason I had to miss the classes with no additional fees. I understand that if I attend as session under the influence, I would be asked to leave and will have to restart the program from the first session and repay for the program at \$160.00. I understand the ADETS Classes will be held for 3.15 hours per sessions and I will have completed a 15-45 minutes Intake/Orientation session prior to attending the class. I further agree to participate in class and understand at the end of this class I will receive an ADETS certificate of completion.

I certify that I have read and understand this Client Contract.

Signed in acknowledgement at time of assessment:

\*

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Dr. Latasha S. McIlwaine, Ed.D., LPC, LCAS, LPCS, CCS, SAP, MAC \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

Signed in acknowledgement at time of enrollment into education/treatment:

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Dr. Latasha S. McIlwaine, Ed.D., LPC, LCAS, LPCS, CCS, SAP, MAC \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

## CLIENT RIGHTS/GRIEVANCES DOCUMENT

### Client Rights:

I understand my basic rights as a client. These rights include:

- 1) The right to be treated with respect, consideration, dignity, and full recognition of individuality and the right to privacy.
- 2) To receive care and services which are adequate, appropriate, and in compliance with relevant state and federal laws, rules and regulations.
- 3) To be free from mental and physical abuse, neglect and exploitation.
- 4) To be free from chemical and physical restraint.
- 5) To have personal and medical record kept confidential and not be disclosed without written consent of the individual or legally responsible person.
- 6) To be encouraged to exercise their rights as a citizen and a client, and to be permitted to make complaints and suggestions without fear of coercion or retaliation.
- 7) To have freedom to participate, or to refuse participation in accessible community activities, and in social, political, medical and religious resources.
- 8) To be notified should program funding be discontinued.
- 9) To have dignity, privacy, and human care in the provision of personal health care.
- 10) To contact the Disability Rights of NC, which is the North Carolina State agency responsible to protect and advocate the rights of persons with disabilities.
- 11) To keep and use personal property and clothing under appropriate supervision, unless specifically prohibited by law.
- 12) To know the rules that the client is expected to follow and possible penalties for violations.
- 13) To know the client's protection regarding disclosure of confidential information, as delineated in GS 122c-52 through GS 122c-56.
- 14) To be informed of the procedure for obtaining a copy of the client's treatment/habilitation plan.
- 15) To understand the agency policy regarding fee assessment and collection practices for services.
- 16) To understand the grievance procedures including the individual to contact and description of the assistance the client will be provided.
- 17) To understand the policy on suspension and expulsion from service.
- 18) To understand that search and seizure is not allowed by this agency.
- 19) To understand the purposes, goals and reinforcement structure of any behavior management system that is allowed.
- 20) To understand potential rights restrictions.
- 21) To understand the notification provisions regarding the restrictions of client's rights as specified in GS 122c-62(e).

### Grievance Policy:

I understand that if I have a complaint/grievance, I should:

Contact Latasha S. McIlwaine at (704) 492-1105

Efforts should be geared toward amicable resolve of any issues with the consideration of time line as outlined. A client can request that a complaint become a formal grievance during anytime if the complaint process.

All complaints will be treated with respect and confidentiality. Insightful Options, PLLC management staff will follow-up on any grievance filed by clients or guardians. When a consumer or legally responsible person has a concern, complaint or grievance with the services or treatment of any kind, he or she should report the matter in question to the Qualified Professional or any staff member responsible for their service provision for immediate resolution.

When appropriate, the Executive Director or Other Designated Staff may be included in this meeting and solicit the client's/LRP input to expedite and resolve the issue in question as quickly as possible and within the agency timelines of less than thirty (30) working days.

All formal complaints will be acknowledged and documented by staff utilizing the *Insightful Options, PLLC Complaint or Grievance Form*.

When a client or legally responsible person who receives services with Insightful Options, PLLC has any complaints, concerns of grievances towards treatment received or other issues of great concern, the following procedures shall be followed.

**Immediate Action:** The client, guardian or legally responsible person should be encouraged to first discuss the concern with any staff member with whom the individual is comfortable with to hear the immediate concerns. It is recommended however, that the complainant discuss their concerns with the immediate supervisor.

**2-Working Days:** Within 2 working days, the Supervisor or Qualified Professional must meet with the client/LRP after receiving the formal complaint to discuss the concern. The Complaint Grievance Form will be completed at this point. If the complaint has been made against a Supervisor, it shall then be forwarded up to the next person in the chain of supervision who will assist the complainant in completing the Complaint Grievance Form.

**5-Working Days:** Within 5 working days of the completion of the Complaint Grievance Form and the meeting with the immediate Supervisor or Qualified Professional, the complainant will be given the opportunity to meet with a Designated Administrative Level staff who will investigate the complaint if the complainant is still not satisfied with any recommended resolutions given by the Immediate Supervisor or Qualified Professional.

**If the complainant is satisfied with the decision, then the complaint is officially closed at this level.**

**8-Working Days:** If the complainant is not satisfied with the decision made by the Designated Administrative Level staff, the complaint or grievance will be forwarded to the Executive Director, whom shall review the complaint. Within 10 working days the Executive Director shall make a decision. If the complainant is not satisfied with the decision, he or she will have the opportunity to present the complaint to the Client Rights Committee.

**18-Working Days:** Once the Executive Director informs the Client Rights Committee regarding the outcome of the complaint, the CRC Committee shall investigate the complaint next.

**30 Working Days:** By the end of the 30<sup>th</sup> day the Client Rights Committee shall evaluate the concerns and meet the client or legally responsible person to discuss their findings. Final decision is made by the Client Rights Committee.

★ ☐ I understand that I have a right to contact the agencies below at any time to discuss my complaint/grievance:

**DWI Services, Justice Systems Innovations**

**NC Mental Health/Developmental Disabilities/Substance Abuse Services**

Shenita Billups

Donna Brown

3008 Mail Service Center Raleigh, NC 27699-3008

Phone: 919-733-0566 Fax: 919-508-0963

**North Carolina Substance Abuse Professional Practice Board**

Katie Gilmore, Associate Executive Director

P.O. Box 10126 Raleigh, NC 27605

**Disability Rights NC**



# **INSIGHTFUL OPTIONS, PLLC**

## **CONSENT TO INDIVIDUAL RECIPIENT 42 CFR Part 2 and HIPAA**

I, \* \_\_\_\_\_, authorize \_\_\_\_\_

(patient's name)

to disclose

(name or general designation of individual or entity making the disclosure)

ES08, Driving Record, Citation, and BAC Reading, Assessment and Recommendations  
[describe how much/what kind of information may be disclosed, including and explicit description of what substance use disorder information may be disclosed; as limited as possible]

to \_\_\_\_\_ Insightful Options, PLLC Telephone 704-492-1105 and Fax 704-969-7298

(name of individual(s) who will receive the information)

for the purpose of \_\_\_\_\_ Coordination of Services

(describe the purpose of the disclosure; as specific as possible)

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

[describe date/event/ condition upon which consent will expire; must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

**I have been provided a copy of this form.**

Dated: \_\_\_\_\_ \* \_\_\_\_\_  
Signature of Patient

Dated: \_\_\_\_\_  
Signature of person signing form if not patient

### **Describe authority to sign on behalf of patient**

Dated: \_\_\_\_\_ Dr. Latasha S. McIlwaine, Ed.D., LPC, LCAS, LPCS, CCS, SAP, MAC  
Witness/Staff Signature

**Notice Prohibiting re-disclosure of Substance Use Disorder Information:** This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §2.12(c)(5) and §2.65.

Insightful Options, PLLC- Counseling and Consulting Services  
615 East 6<sup>th</sup> Street, Suite 2A, Charlotte NC 28202/ 176 West Franklin Blvd, Gastonia, NC 282052  
704 492 1105





operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: \_\_\_\_\_ \*

*Signature of Patient*

Dated: \_\_\_\_\_

*Signature of person signing form if not patient*

*Describe authority to sign on behalf of patient*

Dated: \_\_\_\_\_ *Dr. Latasha S. McIlwaine, Ed.D., LPC, LCAS, LPCS, CCS, SAP, MAC* \_\_\_\_\_

*Witness/Staff Signature*

Notice Prohibiting re-disclosure of Substance Use Disorder Information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §2.12(c)(5) and §2.65.



**INSIGHTFUL OPTIONS, PLLC**

**CONSENT TO THIRD PARTY PAYER RECIPIENT**  
42 CFR Part 2 and HIPAA

I, [signature], authorize \_\_\_\_\_  
 (patient's name)

[name or general designation of individual or entity making the disclosure]	to disclose
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*[Describe how much/what kind of information may be disclosed, including and explicit description of what substance use disorder information may be disclosed; as limited as possible]*

to \_\_\_\_\_  
[name of third-party payer]

for the purpose of \_\_\_\_\_  
*(describe the purpose of the disclosure; as specific as possible)*

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

*[describe date/event/ condition upon which consent will expire; must be no longer than reasonably necessary to serve the purpose of this consent]*

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: \_\_\_\_\_ \* \_\_\_\_\_  
Signature of Patient

Signature of Patient

Dated: \_\_\_\_\_  
Signature of person signing form if not patient

Signature of person signing form if not patient

## Describe authority to sign on behalf of patient

Dated: \_\_\_\_\_ Dr. Latasha S. McIlwaine, Ed.D., LPC, LCAS, LPCS, CCS, SAP, MAC \_\_\_\_\_  
*Witness/Staff Signature*

Witness/Staff Signature \_\_\_\_\_

**Notice Prohibiting re-disclosure of Substance Use Disorder Information:** This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §2.12(c)(5) and §2.65.

Insightful Options, PLLC- Counseling and Consulting Services  
615 East 6<sup>th</sup> Street, Suite 2A, Charlotte NC 28202/ 176 West Franklin Blvd, Gastonia, NC 28205  
704.492.1105

**INSIGHTFUL OPTIONS, PLLC**  
**CONSENT TO TREATING PROVIDER ENTITY RECIPIENT**  
**42 CFR Part 2 and HIPAA**

**REMINDER:** Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting redisclosure. A "treating provider relationship" exists when a patient receives, agrees to receive, or is legally required to receive diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required for a treating provider relationship to exist. This consent form is for use when a patient wishes to authorize the disclosure of their substance use disorder information to an individual or entity with which the patient has a treating provider relationship.

I, \* [patient's name], authorize  
[name or general designation of individual or entity making the disclosure] to disclose

[describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information may be disclosed; as limited as possible]  
 to [name of recipient entity, which has a treating provider relationship with the patient]

for the purpose of [describe the purpose of the disclosure; as specific as possible]

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

[describe date/event/condition upon which consent will expire; must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

**I have been provided a copy of this form.**

Dated: \* [Signature of Patient]

Dated: [Signature of person signing form if not patient]

**Describe authority to sign on behalf of patient**

Dated: Dr. Latasha S. McIlwaine, Ed.D., LPC, LCAS, LPCS, CCS, SAP, MAC  
Witness/Staff Signature

**Notice Prohibiting re-disclosure of Substance Use Disorder Information:** This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §2.12(c)(5) and §2.65.