ABLE Counseling & Assessment Services, P.L.L.C.

Specializing in Substance Abuse Assessments & Outpatient Treatment

4919 Monroe Road Charlotte, NC 28205 **Phone**: 704-568-1122 **Fax**: 980-309-0754

Assessment Date: _____ DOB: _____-_____-_____ MRN#: _____

MM - DD - YYYY

Full Name: _____ SS# _____

Address: _____ City: _____ State _____ Zip _____

Phone Number : ( ) _____ ( ) _____ Email: _____

M [ ] F [ ] _____ S M D W ☐ YES NO ☐

Gender Race/ Ethnicity Marital Status Are you a Student

☐ YES NO ☐ ☐ YES NO ☐ _____

Do you live alone Do you have children Ages

Education: Less than 6th [ ] Less than 9th [ ] Less than 12th [ ] Completed HS/GED [ ] Served in the Military: YES NO

Some College [ ] Bachelors Degree [ ] Graduate Degree or Higher [ ] Branch:_____ Other:_____

Employer: _____ Occupation: _____

How long: _____ Days Worked : _____ Work Hours: _____ Part – Time [ ] Full – Time [ ]

Briefly state your reason for our services: DWI [ ] DWLR [ ] POSSESSION [ ] Other:_____

☐ YES NO ☐ ☐ YES NO ☐

Have you been a client here before If yes, when _____ Have you been arrested for DWI Arrest Date: _____

# of prior Alcohol/Drug arrests: _____ # of prior Alcohol/Drug treatments: _____

Docket#: _____ Court Date: _____ County of Arrest: _____

Blood Alcohol Level: _____ Conviction Date: _____

NC Driver's License Number or Customer Number: List **ALL** states previously licensed:

_____ _____

Attorney: _____ Phone: _____ Fax: _____

Are you on probation [ ] or parole[ ]: _____ Officer's name: _____

I hereby attest that statements and information that I have provided are true.
I understand that this information will be used to recommend the best service for me.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES STATEMENT OF CLIENT RIGHTS

Name: _____ DOB: _____

Client Rights:

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

1. The right to impartial access to treatment services regardless of race, religion, ethnic background, physical handicap or source of financial support.
2. The right to have personal dignity recognized and respected in all aspects of interaction and contact with facility staff.
3. The right to individualized treatment, including participation in the development of a treatment plan and implementation of the plan in cooperation with professional staff.
4. The right to confidentiality of communication with treatment staff and of material included in the treatment record; federal confidentiality rules (42 CFR part 2) prohibits the release of any information about a client's participation in this program to anyone outside of this agency without a client's written authorization for the disclosure of my protected health information.
5. The right to privacy of health information, under HIPAA, (Health Insurance Portability and Accountability Act), rules accept where federal or state rules are more restrictive. HIPAA Notice of Privacy Practice is given to all clients extensively explaining the rules and exceptions to confidentiality in special cases of imminent emergency or court order.
6. The right to express opinions and discuss the plan and course of treatment with persons responsible and to receive a stated grievance in accordance with established policy.
7. The right to be informed of any rules or expectations, which apply to the client's conduct and participation in treatment.
8. The right to a satisfactory explanation of treatment services and this statement of rights before giving consent to treatment.
9. The right to notify the staff of discontinuance of treatment at any time without being financially responsible for any planned treatment services that was not provided.
10. The right to be informed of alternative treatment resources other than those provided by ACAS, PLLC

I have reviewed and understand my rights as a client of ACAS, PLLC

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

Name: _____ DOB: _____

Grievance Policy

You may submit Concerns/Grievances in writing to **ACAS, PLLC.** You will receive a call within 48 hours to discuss your Concerns/Grievances. If unresolved, you may contact State Office of DWI Services

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 shenita.billups@dhhs.nc.gov

Donna Brown donna.m.brown@dhhs.nc.gov

3008 Mail Service Center Raleigh, NC 27699-3008
Phone: 919-733-0566 Fax: 919-508-0963

North Carolina Substance Abuse Professional Practice Board

http://www.ncsappb.org/

http://www.ncsappb.org/wp-content/uploads/2012/11/complaints.pdf

P.O. Box 10126 Raleigh, NC 27605

Katie Gilmore, Associate Executive Director
katie@recanc.com

Disability Rights NC
http://www.disabilityrightsnc.org/
3724 National Drive, Suite 100
Raleigh, NC 27612
(877) 235-4210 or (919) 856-2195
Email: info@disabilityrightsnc.org

I certify that I have received a copy of this Client Rights/Grievance Policy.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

Service Agreement

Name: _____ DOB: _____

Reinstatement of Driver's License:

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

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

Provider Choice:

Initial
____ I understand that I have the right to choose to complete my recommended level of substance abuse treatment or education at **any** authorized NC DWI Services provider.
The following resources are available to assist you in finding an authorized NC DWI Services provider in NC:
NC DWI Services Provider List by County: www.ncdwiservices.org
NC DWI Services Main Phone Number: 919-733-0566

Service Level Recommendations:

Initial
____ I understand that the following is required to be completed to clear my license.
Level: _____

Minimum # of hours: _____

Duration (Minimum # of days): _____

Additional requirements (i.e., UDS, BAC): _____

Assessment Policy:

Initial
____I understand that if I have **not** begun the recommended substance abuse education or treatment to resolve my DWI within **(six months)** from the assessment date a new assessment and assessment fee will be required.

Complete Driving History:

Initial
____I understand that a complete driving history from NC DMV is required for the assessment; I may bring one in or obtain it from this facility **at the cost** I would have incurred if I obtained it myself online at www.ncdot.gov/dmv/online/records/.

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Name: _____ DOB: _____

Program Requirements and Fees:

Initial

___I understand that if I complete the recommended level of care at a ABLE Counseling & Assessment Services, these will be the program requirements and fees:

ADETS: $160
*ABLE Counseling will pay $9/workbook for ADETS clients and $25/workbook for non-ADETS clients.
20-39 Short Term = $325 - $500
40-89 Longer Term = $625 - $1,500
In State Review: $100.00
Out of State Review: $150.00

*I will be required to pay a $50 reinstatement fee. I will be required to pay the full fee to begin the process again if more than one month has passed
*Abstinence from alcohol and/or drugs is required during your treatment. Random breath and urinalysis are a part of treatment. If a positive result should occur; additional AA meetings and/or treatment sessions will be required at clinician's discretion.

* Motor Vehicle Records obtained by this facility for the purpose of the DWI Assessment are at No Cost to the client AND clients SHOULD NOT BE REQUIRED to provide a MVR, as it is included in the assessment cost. UDS Conducted by this facility as a part of the DWI Assessment are at No Cost to the client.
The cost of this program is payable by cash, credit/debit card or money order. Checks are not accepted.

Each treatment client must be scheduled to attend services weekly (10A NCAC 27G .3813).

Certificate of Completion (E508) Processing:

Initial

___I understand that the provider has two weeks to submit the E508 after completion of services and payment. If you are pre-trial at time of assessment, you MUST inform your Treatment Provider of your conviction date in order to submit the E508 to the state. *An additional period of 5 days or more is required to complete the process with DMV. Contact your Treatment Provider with questions regarding the status of your E508.*

I certify that I have read, understand, and have received a copy of this Service Agreement.

Signed in acknowledgement at time of assessment:

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

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

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION CRIMINAL JUSTICE SYSTEM REFERRAL 42 CFR Part 2 and HIPAA

I, _____, authorize

[Patient's full name]

_____Able Counseling & Assessment Services - Charlotte_____ to disclose to one another:

[Name or general designation of individual or entity making the disclosure] Assessment Center

Initial all that apply: ☐ NC Department of Community Corrections (PO): _____

☐ NC DMV ☐ NC Division of MH/DD/SAS ☐ _____

[Name of the Criminal Defense Attorney]

☐ _____ ☐ _____

[Name of the appropriate court] *[Name of the prosecuting District Attorney]*

☐ _____

[- Other -]

the following information:

☐ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and/or

☐ _____

[describe how much/what kind of information may be disclosed, including & explicit description of what substance use disorder information may be disclosed; as limited as possible]

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: _____ _____

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.