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: _____________

Home/Cell Phone#: (______)______________ (____)_________________ Email: ______________________________________

Gender: **M [ ] F [ ]** Race: __________________ Ethnicity: ______________________________

Are you a Student: **YES [ ] NO [ ]** **Education:** Lees than 6th[ ] Less than 9th[ ] Less than 12th[ ] Complete HS/GED [}
Some College[ ] Bachelors Degree[ ] Graduate Degree or Higher[ ]

Marital Status: **S M D W**

Do you live alone: **YES [ ] NO [ ]** Do you have children: **YES [ ] NO [ ]** Ages_________________

Served in the Military: _______________________ 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**:____________________________

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 or Customer #_______________________ 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: ________________

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: ______________

Contract with Client for Services

Name: ___________________________________ **DOB:** ____________________________

Requirements for reinstatement of your driver's 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 and
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 is this area from which I may choose to complete my recommended level of care:
http://www.ncdhhs.gov/mhddsas/services/dwi/locateservices.htm 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 ***valid for SIX months***. If I have **not** begun the recommended DWI/ Substance Abuse treatment or education within SIX months from the assessment date a new assessment and assessment fee will be required.

Program Requirements and Fees:
Should you choose to complete your recommended level of care at ACAS these are the program requirements and fees:

*I will be on time for each scheduled session. If unable to attend a session, I must call 704-568-1122 in advance to reschedule.

*If I miss a session, I will be required to attend another session of the same topic to complete treatment.

*If I miss more than 3 sessions unexcused, termination from treatment will occur. If I want to re-attend TX within one month.

Name: ___________________________________ **DOB:** ____________________________

*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.

ADETS: $160

*ABLE Counseling will pay $9/workbook for ADETS clients and $25/workbook for non-ADETS clients.

20-39 Short Term = $300 - $600

40-89 Longer Term = $600 - $1500

In State Review: $100.00

Out of State Review: $150.00

Certificate of Completion (E-508) Processing: Please note that it may take up to 5 business days or longer for your form to be processed and approved, <u>after</u> it is submitted by your Provider.

<u>**I certify that I have received a copy of this Consent for Service**</u>

Client Signature: _________________________________ Date: __________________

Staff Signature: ___________________________________ Date: __________________

Emergency Contact

Name:____

Phone#: ____________________

Address:_______________________________________

This consent is valid from __________________ to _________________ and may be revoked by me at any time.

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION CRIMINAL JUSTICE SYSTEM REFERRAL

I, ____ authorize:
(Printed name of defendant)

Initial all that apply:

Name or general designation of program making disclosure: Able Counseling and assessment Services

___ NC Department of Community Corrections (Officer supervising my case): __________________

___ NC Division of Motor Vehicles, for purposes of license reinstatement

___ NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

____

(Name of the appropriate court)

____

(Name of the prosecuting District Attorney)

____

(Name of the Criminal Defense Attorney)

____

(Treatment Center)

____

to communicate with and disclose to one another the following information (my diagnosis, treatment recommendation, urinalysis /breathalyzer results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

____

The purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing
Confidentiality of Alcohol and Drug Abuse 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. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:
_____there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

____

(Specify other time when consent can be revoked and/or expires)
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: ________________________________ Date: ____________
(Signature of Patient)

Signature of person signing form if not the patient: ______________________Date: ____________
Describe authority to sign on behalf of patient:

Staff signature: _________________________