SOUL CARE
Application for Services

PLEASE COMPLETE ALL SECTIONS IN BLACK INK ONLY

Date:

Name: ____

Date of Birth _______________________________ **Race** ____

Present address (City, State, Zip): ____

How long Social Security No. _______ – _____ – _________
Insurance Type/Number _____________________________________**Telephone (___)**_____________
Age of applicant ____________________
Currently resides with __________________________________
Legal Guardian Name ____
Relationship to applicant ________________________________
Address (City, State, Zip) ____
Telephone ____
Name any medications you are taking, and for what condition(s): _____________
____
Name of physician _______________________________ **Telephone** _____________________________
Address ____

SPIRITUAL INFORMATION:
What is your spiritual orientation? ________________________
Do you attend a local church? ___ **Yes** ___ **No**
If yes, please provide church name: ____

EDUCATIONAL INFORMATION: Assigned School Grade (_____)
Current school applicant attends: ________________________________

____ _______________
Client Date

____ _______________
Parent/Legal Guardian Signature Date
(If Applicable)

____ _______________
Witness Date

EMERGENCY CONTACT FORM

I ________________________, as the legal guardian of _______________________, give SOUL CARE and the providers of SOUL CARE permission to access the following contacts in case of emergency and to provide necessary medical attention to me / my child.

Emergency Contact Person(s)

Name: ____________________________________ Relationship: ________________

Address: ____

Phone #: (H) ______________________________ (W)________________________

Name: ____________________________________ Relationship: ________________

Address: ____

Phone #: (H) ______________________________ (W)________________________

Emergency Medical

Preferred Physician:
Name: ____
Address: ____
____
Phone #: ____

Preferred Dentist:
Name: ____
Address: ____
____
Phone #: ____

Preferred Optometrist:
Name: ____
Address: ____
____
Phone #: ____

My signature below indicated that I grant SOUL CARE permission to contact the above named individuals in case of an emergency, sudden illness or accident. I further grant permission for SOUL CARE to seek emergency care for me/my child (circle one) from Emergency Services, a hospital, or a physician.

____ ________________
Client Date

____ ________________
Parent/Legal Guardian Signature Date
(If Applicable)

____ ________________
Witness Date

5501 Executive Center Drive, Suite #215, Charlotte, NC 28212
Tel: 980-613-8312 Fax: 888-972-4998 Email: info@mysoulcare.org Website: www.mysoulcare.org
Care For Your Soul, Care For Your Life…3 John 1:2

Consent to Receive Treatment Form

I, ______________________________________, have discussed with the staff of SOUL CARE, Inc. the following indicated/requested services:

__X_ Comprehensive Clinical Assessment

____ Individual/Family Counseling ____ Group Counseling ____ Medical Services ____ Tele-Health Counseling

____ Other (Describe): ______________________________

As a client, I further understand that I shall be treated with respect to the basic rights of dignity, privacy and humane care and retain the right to:

Be informed of the qualifications of professionals rendering services.
Approve the release of confidential information about myself.
Receive an individualized, written service plan which includes the anticipated goals, as well as services to be provided in order to achieve those goals.
File a formal grievance, if necessary, against employees, foster parents, interns or any associated providing services for SOUL CARE. If I need assistance filing such grievance, I understand the SOUL CARE, Program Director, or designee will assist me with this process.
To contact The Governor's Academy Council at any time at (800) 821-6922.
To be made aware of the rules I am expected to follow.

My signature below reflects my understanding of my rights, my consent of such services and my full participation and freedom of choice in the treatment planning process. I also understand if any additional services not already indicated may be recommended, I will have further opportunity to participate in the planning of such additional services. I understand I can withdraw my consent at any time unless I have been ordered to receive such services by Court Order.

____ ________________
Client Date

____ ________________
Parent/Legal Guardian Signature Date
(If Applicable)

____ ________________
Witness Date

Consent for Counseling from a Christian Worldview

My signature below confirms that I desire psychological counseling from a wholistic perspective involving assessment and interventions in the spiritual, emotional, physical, and social realms from a Christian worldview by my therapist at Soul Care.

Since I embrace the Christian spiritual perspective, I desire that my therapist use the language and practices applicable to that worldview. I do not want language and practices used from other worldview, such as secular, humanist, New Age, atheistic, or Eastern worldviews.

From my Christian perspective, I agree to the use of one or more of the commonly used Christian spiritual disciplines as part of my treatment plan when spiritual issues are being addressed in my sessions with my Soul Care therapist.

I understand that no organized religion or religious denomination is being promoted by my therapist or by Soul Care in general, but he/she is working solely from a biblical worldview.

I understand also that I may experience spiritual confusion or interference in my thoughts by the interplay of spiritual and psychological realities as described below:

- Distressing, unresolved memories may surface through the use of spiritual conflict procedures.
- Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.
- Subsequent to the treatment sessions, the processing of incident/material may continue, and other dreams, memories, flashbacks, feelings, and the like may surface.

I further understand that the spiritual dimension is focused on as a part of my overall treatment plan and is not exclusively the focus of treatment.

I understand that I will seek support from my own church and pastoral resource for questions and issues that involve specific doctrinal, religious, or personal spiritual quests and practices.

I understand that spiritual interventions are used when they are intertwined with my psychological and social issues.

I further give my permission for my therapist to discuss with me issues of the afterlife.

Client/Legal Guardian:________________________ Therapist: __________________________________

Date: ___________________ Date: ___________________

Informed Consent for Tele-Health Services

I hereby consent to engage in distance counseling with **Soul Care, PLLC** as part of my psychotherapy. I understand that distance counseling includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to distance counseling:

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

The laws that protect the confidentiality of my medical information also apply to distance counseling. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I understand that there are risks and consequences from distance counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. These risks are offset by my therapist's use of a HIPAA-compliant service that is encrypted for video telemental health communications.

I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services, group therapy), I will be referred to a psychotherapist who can provide such services in my area.

I understand that I may benefit from distance counseling, but that results cannot be guaranteed or assured.

Considerations:
It is important to note that there are limitations of distance counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations, I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the counseling session.
4. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
5. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

I have read and understood the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

____ ______________
Client Date

____ ______________
Parent/Legal Guardian Signature Date
(If Applicable)

____ ______________
Witness Date

Cancellation and No Show 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 $35 missed appointment fee*. I understand that the missed appointment fee will be due at the next session. Additionally, if I miss 3 appointments my case may be terminated at the discretion of my assigned therapist.

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 – include number: ______________________________
Is it okay to leave a voicemail: ☐Yes ☐No

__________ Email – list email address: ________________________________
____

__________ US Mail – list address: __________________________________
____

__________ Other (including fax): ___________________________________

____
Signature of client or legal guardian

____
Date

*This charge does not apply to Medicaid recipients.

Soul Care

AUTHORIZATION TO RELEASE INFORMATION

*Client Name:

*Date: DOB: Record Number:

I authorize ___**Soul Care, PLLC**_____________________ to release information reciprocal to and from:

Name: ____ Title:

Address: ____
(street) (city) (state) (zip code)

Agency/Insurance Company:_ Phone: _(___)__________

Information to be release: __ Verbally ___ In Writing ___ By Fax

Specific Information to be released: **clinical documentation, educational information, discharge summaries and court reports**

Specific Purpose: **To facilitate access to services**

This consent shall be valid until: ____
(date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Director/Designee of SOUL CARE. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release

*Client's Signature ____ Date _________________

*Parent/Legal Guardian ____ Date _________________

Witness ____ Date _________________

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 <u>control</u> over their health information
It sets <u>boundaries</u> on the use and release of health records
It establishes appropriate <u>safeguards</u> that health care providers and others must achieve to protect the privacy of health information.
It holds violators <u>accountable</u> with civil and criminal penalties that can be imposed if they violate patients' privacy rights.
It strikes a balance when <u>public responsibility</u> requires disclosure of some forms of date – for example, to protect public health.

<u>What does this mean for everyday practice?</u>
In many ways, it is business as usual for SOUL CARE providers. It requires that we:
Obtain written authorization to release information about clients to other health professionals, or parties involved with a client's well-being.
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 clients person information (i.e. talking about clients 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 SOUL CARE client information).
Ensure that when disclosure is appropriate and authorized, that information be limited to the amount of information reasonable 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 Soul Care 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 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 SOUL CARE .
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.

____ ________________
Client Date

____ ________________
Parent/Legal Guardian Signature Date
(If Applicable)

____ ________________
Witness Date

Notice of Privacy Practices/Disclosure Statement

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

As a client of SOUL CARE , 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 Soul Care 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 Soul Care PLLC has to share confidential information about a person served without consent Soul Care 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. Soul Care PLLC will also document it in your service record.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is a physical property of SOUL CARE , 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 SOUL CARE 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:

SOUL CARE 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. SOUL CARE 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. SOUL CARE 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 notified. SOUL CARE 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.

I acknowledge that I have read and understand SOUL CARE'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.

Effective Date:

I have read, understand, and have received a copy of this Notice of Privacy Practices/Disclosure Statement:

____ ______________
Signature of Client Date

____ ______________
Signature of Legal Guardian Date

____ ______________
Signature of Witness / Title Date

Soul Care

Your Rights as a Client in Our Care

INFORMATION ON CLIENT RIGHTS & RESPONSIBILITIES
North Carolina General Statutes (GS 122C 51-67) and the North Carolina Administrative Code (APSM 95-2) outline specific requirements for notification of individuals regarding their rights as well as operational policies and procedures that ensure the protection of rights. These statutes and regulations also outline the policy and operational requirements for the use and follow up of restrictive interventions and protective devices.

The protection and promotion of recipient rights is a crucial component of the service delivery system. All individuals are assured rights by law and it is expected that providers will respect these rights at all times and provide their service recipients continual education regarding their rights, as well as support them in exercising their rights fully.

Basic Human Rights Provided to Every Client

- Right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect and exploitation
- Right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability.
- Right of our clients to receive services and participate in activities free of discrimination on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws.
- Right to treatment and care based on the normalization principle
- Right to receive age-appropriate treatment, access to medical care and habilitation, and the right to an individualized written program plan at the time of admission to maximize his/her development
- Right to be informed in advance of the potential risks and alleged benefits, and alternatives to the program choices
- Right to confidentiality of all records and information about their health, social, or financial circumstances
- Right to be free from unnecessary or excessive medication. Medication shall not be used for punishment, discipline or staff convenience
- Right to consent to or to refuse any treatment offered, including behavior management policies, except in certain emergency situations
- Right to request notification after occurrence of any or specified interventions
- Right to be informed of emergency procedures
- Right to exercise all civil rights. Certain civil rights may be limited if a client has been adjudicated incompetent.
- Right to certain safeguards and carefully controlled circumstances when interventions are used
- Right to be free of corporal punishment, and to be free of harm, abuse and exploitation
- Right to be free of restrictive interventions including, but not limited to physical restraint, isolation or seclusion except when there is imminent danger of abuse or injury to oneself or others, when substantial property damage is occurring, or when it's necessary as a part of treatment/habilitation
- Right to be free from threat or fear of unwarranted suspension or expulsion
- Right to be free from unwarranted invasion of privacy
- Right to be free from unwarranted search and/or seizure
- Right of the person legally responsible for a minor or an incompetent adult to request notification of the use of an intervention procedure
- Right to request notification of the restriction of rights
- Right to file a grievance or a complaint with Client Rights Committee:
  Soul Care, 5501 Executive Center Drive, Suite #215, Charlotte, NC 28212
  Tel: 980-613-8312
- Right to contact the North Carolina Legal Assistance:
  2113 Cameron Street, Suite 218, Raleigh, NC 27605
  1-800-821-6922 (Voice) or 1-888-268-5535 (TDD)
- Right to contact the Disability Rights North Carolina (formerly the Governor's Advocacy Council for Persons with Disabilities); at the Division of MH/DD/SAS
  3724 National Drive, Suite 100
  Raleigh, NC 27612
  Toll-Free: 877-235-4210

What Are My Responsibilities?

In addition to your rights as a recipient of services, you can help ensure the best outcomes for yourself by assuming the following responsibilities:

- Supplying information (to the extent possible) that Soul Care PLLC and its network providers/practitioners need in order to provide you care
- Following the plans and instructions for care that you have agreed to with your providers/practitioners
- Understanding your health problems and participating in developing mutually agreed upon treatment goals, to the degree possible.
- Telling the doctor or nurse about any changes in your health.
- Asking questions when you do not understand your care or what you are expected to do
- Inviting people who will be helpful and supportive to you to be included in your treatment planning
- Respecting the rights and property of other consumers and of program staff
- Respecting other consumers' needs for privacy
- Working on the goals of your Treatment Plan
- Keeping all the scheduled appointments that you can
- If unable to keep an appointment, canceling it at least 24 hours in advance
- Meeting financial obligations according to your established agreement
- Informing staff of any medical condition that is contagious
- Taking medications as they are prescribed for you
- Telling your doctor if you are having unpleasant side effects from your medications, or if your medications do not seem to be working to help you feel better
- Telling your doctor or therapist if you do not agree with their recommendations
- Telling your doctor or therapist when/if you want to end treatment
- Carrying your Medicaid or other insurance card with you at all times
- Cooperating with those trying to care for you
- Being considerate of other patients and family members
- Seeking out additional support services in your community
- Reading, or having read to you, written notices from Soul Care PLLC about changes in benefits, services or providers
- When you leave a program, requesting a discharge plan, being sure you understand it and being committed to following it

Confidential information regarding persons being treated for substance abuse shall be released or disclosed in accordance with the federal regulations 42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. Unless such information is court ordered or by other authorized tribunal, a written authorization from the client's is required to release substance abuse information. Disclosure is also permitted in medical emergencies, to qualified personnel for research, audit purposes or program evaluation. Federal Law does not protect any information about suspected child abuse or neglect, crimes committed by a client either at the Mental Health Facility or against any person who works for the facility or about any threats to commit such crimes.

North Carolina statutes and courts prohibit certain types of health information from remaining confidential and impose a duty on the recipient of such health information to report it to the appropriate authorities, such as suspicion of child abuse and neglect of dependent children and the abuse and exploitation of disabled adults.

NOTIFICATION OF RECEIPT OF CLIENT RIGHTS - CLIENT*

I have received and read a copy of "Your Rights as a Client in Our Care" which is a written summary of 122C, Article 3. I understand it's contents regarding client rights and responsibilities. Staff has answered my questions. I also understand that specific programs may have additional policies and procedures pertaining to client rights and that those will be explained to me upon entry into the program.

I have received the following information:

Program consent delineating rules and responsibilities that I am expected to follow, and that I accept the penalties for any violation of the rules; (not applicable to diagnostic assessments)
Protection regarding disclosure of confidentiality;
Procedure for obtaining a copy of my treatment plan (not applicable for diagnostic assessment);
Policies addressing fee assessment and collection practices for my treatment and habilitation;
Grievance policy/procedure;
Suspension and expulsion policy notification (not applicable to diagnostic assessments or case management);
**Search and seizure policy notification (not applicable to diagnostic assessments)

__________________________________ ______________________
Client/Legally Responsible Person's Signature **Date**

__________________________________ ______________________
Witness **Date**

**Documented and placed in Service Record upon admission to service.

Grievance Policy

SOUL CARE maintains a process by which client grievances may be addressed in a fair, timely and impartial matter. This policy specifies how clients, family members, significant others and staff may express concern about the provision of services and what response they may expect.

Grievance may be filed on behalf of a client by:

The client

The client's legally responsible person

Any other adult, including a staff member, who has be designated by the client and given written consent to bring a grievance on his/her behalf.

Procedure:

1. Grievances being made by the client should be made first to the staff person with whom the client has a disagreement.
2. If the client is not satisfied with the response from the staff member, the client should submit a formal grievance in writing, outlining the specific grievance, previous steps taken to resolve the grievance, the parties involved and the date and time the grievance if filed. This form should be given to the staff person's supervisor. Clients who need assistance with completing a formal grievance can seek assistance from any employee or staff member of SOUL CARE, without fear of disclosure or retribution by assisting staff.
3. The supervisor will contact the client within 72 hours of receipt and attempt to reach a resolution with the client.
4. If satisfactory resolution is not achieved through the interview with the supervisor, the client may submit the grievance to the Clinical Director/Owner, stating the nature of the grievance, and that the client has not received a satisfactory response to the grievance. The Clinical Director/Owner will respond to the grievance within 72 hours of receipt.
5. Clients who are still not satisfied with the response by the Clinical Director/Owner may forward their grievance directly to the Chair of the Client Rights Committee who will be expected to act on the grievance within 5 working days of receiving it. The Client Rights Committee will investigate the grievance and will deliver an opinion regarding the resolution strategy to the agency director or president. Persons filing a grievance against SOUL CARE should receive a written response regarding their grievance no later than 30 days from the initial grievance filing date (step 2 listed above).

YOU HAVE THE RIGHT TO CONTACT THE FOLLOWING ORGANIZATION AT ANY TIME DURING THIS PROCESS:

North Carolina Division of Mental Health / Developmental Disabilities / Substance Abuse Services
www.ncdhhs.gov/mhddsas
Disability Rights North Carolina: Toll-Free: 877-235-4210
DHHS CARE-LINE: 1-800-662-7030 (Voice/Spanish)

My signature below indicates my understanding of the grievance process. I also acknowledge that I have received a copy of this policy.

____________________	________	________________________	_______
Client	**Date**	**Client's legally responsible party**	**Date**

- CREDIT CARD PAYMENT AUTHORIZATION & PAYMENT POLICY*-

THIS FORM, ONCE COMPLETED, IS FILED IN A HIPAA compliant secured server with ACCESS LIMITED TO ONLY THE PRACTICE MANAGER & OWNER

Thank you for choosing us as your mental health provider. We are committed to providing you with quality and affordable care. Because some of our clients have had questions regarding client and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is the client's responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Co-payments and/or co-insurances elected for payment by credit card will be charged to card on file below.

- My co-payment amount per session is ______; my deductible amount per year is ___________.
- Have you met your deductible for this year? □YES □ NO If no, how much more do you have to pay towards your deductible?__________________

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of visit.

- My session charges not covered by insurance are: Intake Charge_______ / Follow-up Charges_______

4. Proof of insurance. All clients must complete our client information form before seeing the doctor. **We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance.** If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. Most insurance providers will not pay any claims submitted 90 days after date of service.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be referred to another counseling agency. If there is mental health crisis during the referral process, our agency will provide interim emergency services only.

8. Missed appointments. Our policy is to charge a $35 fee for missed appointments that are not canceled 24 hours in advance. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Recurring Credit Card Payment Authorization. It is our policy to obtain credit or debit card information from each client. This is to ensure that all payments will be collected according to the conditions within our payment policy. By completing the following information, you authorizing Soul Care Christian Counseling Services to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for counseling services.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes to my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this card.

It is required that you show your preferred card to us during you first appointment for verification.

** This policy does not apply to Medicaid recipients.*

(Please fill out completely and sign.)

Client Name: ____

Visa ❒ Master Card ❒ Discover ❒ American Express ❒ Other ❒_______________________

Credit Card Number: ____________ - ____________ - ____________ - ____________

Expiration Date: ________(mo.)/________(yr.)

CVC Number (last 3 numbers on the back of the card/4 numbers on the front of an AmEx card): ____________

Signature: ____

Date this form signed: __________________________________

Address with Zipcode:____

Please print name as it appears on Credit Card: ____