NANETTE FLOYD PATTERSON, MA, LPC

CONSENT FOR ASSESSMENT, TREATMENT, AND/OR OTHER SERVICES

Individual's Name: _____ MR#: _____
Insurance #: _____ DOB: _____

I, _____ (consumer/parent/legally responsible person), give my consent for The Seed Planter Coaching & Counseling, PLLC/Nanette Floyd Patterson to provide assessment, treatment and/or other services for the above named consumer. I reserve the right to withdraw consent at any time. I also reserve the right to refuse, at any time, any services offered to me.

If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible. If all modalities are refused, the voluntarily admitted consumer may be discharged.

A minor may seek and receive periodic services from a physician without parental consent for the prevention, diagnosis and treatment of (1) venereal disease and other diseases reportable under G.S. 130A-135, (2) pregnancy, (3) abuse of controlled substances or alcohol, and (4) emotional disturbance.

In a medical or health emergency, I authorize the agency to administer first aid as needed and to contact:

Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

Additionally, in an emergency, a voluntarily admitted consumer may be administered treatment or medication, despite the consumer or the legally responsible person's refusal, even if the consumer's refusal is expressed in a valid advanced written instruction.

I choose the following hospital, medical doctor, and dentist to provide services to me:

Hospital Preference	Address	Phone #
Medical Doctor	Address	Phone #
Dentist	Address	Phone #

If the above medical doctor or dentist cannot be reached, I give my permission to be seen and treated by a licensed physician or dentist or I may be taken to the nearest emergency room by ambulance if necessary. I will not hold this provider/agency accountable for these expenses.

Consumer or Legally Responsible Person Signature	Relationship to Consumer	Date

Witness Signature		Date

NANETTE FLOYD PATTERSON, MA, LPC

CONSENT TO REQUEST PERSONAL AND MEDICAL INFORMATION

Individual's Name: _____ MR#: _____
Insurance #: _____ DOB: _____

I, _____ hereby request and authorize _____ to use or disclose my protected health information to _____.

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (***Please initial beside each applicable document***)

_____ Admission Assessments
_____Medications _____ Treatment Plans _____Treatment Recommendations
_____ Psychiatric Evaluations _____ Psychological Evaluations _____ Progress/Psychotherapy Notes
_____Discharge Summaries _____Aftercare Plans/Orders _____ Lab Results
_____Alcohol/Drug Treatment _____AIDS/HIV
_____ Other: _____

I understand the purpose of the disclosure/redisclosure will be used for:_____

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws. This consent will expire on _____ not more than 365 days from the date of signature.

When this authorization is requested from the consumer, a copy of this signed release form shall be provided to the consumer or legally responsible person. The consumer authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C-53(c).

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, The Seed Planter Coaching & Counseling, PLLC/Nanette Floyd Patterson will obtain a signature and make the appropriate adjustments.

I understand that I may refuse to sign this release of information form. I understand that The Seed Planter Coaching & Counseling, PLLC/Nanette Floyd Patterson may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form.

I understand that The Seed Planter Coaching & Counseling, PLLC/Nanette Floyd Patterson may charge a reasonable fee for copies of my medical records.

_____ _____
Minor Signature (required for SA) *Date*

_____ _____ _____
Signature of Individual /legally responsible person *Relationship* *Date*

_____ _____
Signature of The Seed Planter Coaching & Counseling, PLLC *Date*

NANETTE FLOYD PATTERSON, MA, LPC

CONSUMER ACKNOWLEDGEMENT OF 24 Hour Crisis Coverage

Individual's Name: _____ MR#: _____
Insurance #: _____ DOB: _____

In the event of a behavioral health crisis after business hours please call The Seed Planter Coaching & Counseling, PLLC/Nanette Floyd Patterson at 877-316-3082. Crisis calls will be returned within 60 minutes. In the event of a medical emergency, please call 911 or have someone take you to your nearest emergency room.

Should your provider not be available after business hours, you will be instructed to call:

Pamela E. Williams, MS, LPC, LPCS
NuMe Counseling and Consulting
919-449-7059

I acknowledge that I have received a copy of my provider's 24 hour/ after-hours behavioral health crisis coverage number/information. I understand that this information indicates how to access support for after-hours behavioral health crises only.

_____ _____
Signature of Consumer /Legally Responsible Person (Relationship) Date

_____ _____
Signature of Provider Date

TRANSPORTATION AND EMERGENCY (IF I AM PROVIDING IN HOME COUNSELING)

I, _____, give Nanette Floyd Patterson/The Seed Planter Coaching & Counseling, PLLC permission to drive my child(ren) in a vehicle that is properly insured when necessary. I give Nanette Floyd Patterson/The Seed Planter Coaching & Counseling, PLLC permission to contact the EMS if a medical emergency occurs.

CHRISTIAN COUNSELING

I, _____, understand that Nanette Floyd Patterson is a Christian Counselor who uses biblical and spiritual principles. I am clear that if I do not want Christian Counseling or the Bible mentioned to me that I am to inform her during the initial interaction. I understand that at no time will she push her Christian viewpoints on me. However, if I begin to feel I am being pressured at any level that I am to inform her immediately.

NANETTE FLOYD PATTERSON, MA, LPC

FINANCIAL AGREEMENT/ RESPONSIBILITY

Individual's Name: _____ MR#: _____
Insurance #: _____ DOB: _____

_____ I hereby understand and unconditionally guarantee pre-payment to Nanette Floyd Patterson/The Seed Planter Coaching & Counseling, PLLC for all costs, charges and expenses incurred by said individual at this office, unless separate arrangements are agreed upon in writing (*Does not apply to Medicaid or Health Choice*). Generally, we do not accept checks. However, if an arrangement is made to accept a check, I understand and agree to pay a service charge of $35.00 for any checks that are returned unpaid. I understand if the patient's balance for services provided is not paid within thirty (30) days of billing date, the amount due will be deemed delinquent and a 5% late fee will be charged. No services will be rendered until balanced is paid. In the event legal action should become necessary to collect an unpaid balance due for services rendered to said patient, I agree to pay reasonable attorney's fees or other such costs as the court determines proper (Does not apply to Medicaid or Health Choice). I understand that tele-counseling require pre-payment via PayPal and is not billed to an insurance carrier.

INSURANCE/MANAGED CARE/THIRD PARTY PAYMENT

_____ I understand it is my responsibility to inform the office of any changes in my insurance, prior to the effective date of the change and accept financial responsibility for any office charges that were incurred prior to this date.

_____If I have a third-party reimbursement, I understand it is only for the services they have agreed to cover. I understand that any additional services I desire are being provided outside this insurance arrangement, and I accept full financial responsibility for these services.

I certify the following information to be accurate:

_____**No Third Party Payer.** I have no insurance, or request that no insurance claims be filed by the office. I will accept full financial responsibility for any services the office provides.

_____**Insurance/Out of Network, but No Contract.** I have insurance/third party coverage with: _____. I understand there is not a contract between this payer and the office for this provider's services. I accept financial responsibility for my bill regardless of whatever action my insurer takes. I understand that The Seed Planter Coaching & Counseling, PLLC/Nanette Floyd Patterson will DOES NOT file claims with this carrier. I am clear that I will be given a receipt of services to file personally upon request.

____**Contract with Insurance/In-Network/Third Party.** I have insurance/third party coverage with: _____. I understand there is a contract between this payer and the office for this provider's services. I accept responsibility for any deductibles and co-payments specified by this contract. I request that claims be filed with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office. I accept financial responsibility for any services I desire that are not covered by my insurer.

_____ _____
Signature of Consumer /Legally Responsible Person (Relationship) Date

_____ _____
Signature of Provider Date

NANETTE FLOYD PATTERSON, MA, LPC

ACKNOWLEDGEMENT OF RECEIPT OF INDIVIDUAL'S RIGHTS

Individual's Name: _____ MR#: _____
Insurance #: _____ DOB: _____

The Seed Planter Coaching & Counseling, PLLC/Nanette Floyd Patterson's Individual Right's Policy which covers the following:

- Your rights are guaranteed by law.
- You have the right to a treatment plan.
- You have the right to be informed about medications. (The Seed Planter Coaching & Counseling, PLLC/Nanette Floyd Patterson, does not prescribe or administer medications)
- You have the right to refuse treatment.
- You have the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability.
- You have the right to confidentiality.
- You have the right to be informed of the rules.
- You have the right to know your treatment costs.
- You have the right to privacy.
- You have the right not to be abused.
- You have a special right if you have intellectual disabilities.
- You have the right to make instructions for your treatment in advance.
- You have the right to make a complaint.
- You Have Certain Appeal Rights

By initialing below, I certify that I have reviewed and/or received a copy of the following documents:

_____ Process for Obtaining a Copy of the Treatment Plan
_____ Consent for Assessment, Treatment, and/or Other Services
_____ Consent to Request Personal and Medical Information
_____ Consumer Acknowledgement 24 Hour Behavioral Health Crisis Coverage
_____ Notice of Privacy Practices
_____ Financial Agreement
_____ Treatment Plan
_____ Individual's Rights

I, _____, acknowledge and have received a copy of my right's as a client of Nanette Floyd Patterson/The Seed Planter Coaching & Counseling, PLLC

_____ _____
Individual's *Signature* Date

_____ _____
Signature of consumer /legally responsible person Date

_____ _____
The Seed Planter Coaching & Counseling, PLLC Representative Date