ALLIANCE ASSESSMENTS, LLC

200 NORTHGATE PARK DRIVE, WINSTON SALEM, NC 27106

www.allianceassessments.com | 336-283-9246

ALLIANCE DEMOGRAPHIC INFORMATION FORM

Instructions: Please provide a response for each of the following questions:

Name: _____
First Middle Last

Address: _____
City State Zip

Age: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Social Security Number: _____ Drivers License #: _____

List (all) States where licensed: _____

Phone number to reach you if needed: _____

What is your Marital Status? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

With which racial or ethnic category do you identify?

Race *(Check all that apply)*: ☐ African American ☐ Asian Pacific Islander ☐ White ☐ Latino

Ethnicity: ☐ Hispanic Puerto Rican ☐ Hispanic Mexican American ☐ Hispanic Cuban

☐ Hispanic Other ☐ Unreported ☐ Not Hispanic or Latino ☐ Other _____

Employment: ☐ Full time ☐ Part-time ☐ Unemployed

Name of Employer: _____

Address: _____

Years Employed: _____

Highest Level of Education: _____

Any Current or pending Driving convictions: ☐ Yes ☐ No and if so what is it?

_____

Prior Legal convictions: _____

Reasons for Assessments: _____

Emergency Contact name: _____

Emergency Contact number: _____

CLIENT RIGHTS / GRIEVANCES DOCUMENT

Client Rights:

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

1. The right to impartial access to care, free from any physical or verbal abuse or sexual activity or coercion by staff, and without discrimination due to race, color, sex, age, religion, national origin, sexual orientation, political belief or mental or physical handicap while having the right to exercise all civil, political, personal, or property rights to which I am entitled as a citizen and the pursuit of employment, education, and religious expression.

2. The right to receive care that is suited to my needs in the least restrictive environment available and to be fully informed of the charges for services provided.

3. The right to accept or refuse service unless a physician, licensed psychologist, or licensed clinical social worker feels that refusal would be unsafe for me or others and to participate in the planning of my care, including changes in the plan.

4. The right to be informed, of the name, business telephone number and business address of the person supervising my plan of care and ability to obtain copies of my service record, unless the Director determines that the access requested is not therapeutically in my best interest.

5. The right to be informed of the complaint procedure and to file a complaint without fear of discrimination or retaliation. If I feel I have been deprived of my rights, I have the right to have my complaint investigated by the provide within a reasonable period of time.

Grievance Policy:

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

First address the issue with the Agency Director, Willie Turner, via mobile at 704-213-4104 within 48 hours and then the Clinical Director, Rosalinda Thomas, via mobile at 336-408-5580 also within 48 hours.

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.bbillups@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

https://www.ncsappb.org/

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

Katie Gilmore, Associate Executive Director
Katie@recanc.com
P.O. Box 10126 Raleigh, NC 27605

DISABILITY RIGHTS NC

https://www.disabilityrightsnc.org/

info@disabilityrightsnc.org
3724 National Drive, Suite 100
Raleigh, NC 27612
(877) 235-4210 OR (919) 856-2195

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

Client's Signature: _____ Date: _____

Counselor's Signature/Credential: _____ Date: _____

ALLIANCE ASSESSMENT AND COUNSELING SERVICES

Client ID:

I, _____ hereby authorize Rosalinda Thomas / Alliance Counseling; to disclose to, receive from and communicate with _____ in written, verbal and/or electronic format:

☐ Name

☐ Demographic information (age, address, phone, Social Security Number, etc.)

☐ Reason for Referral

☐ Alcohol / Drug and Legal History

☐ Urinalysis and breathalyzer results

☐ Psychiatric evaluations

☐ Attendance and Progress

☐ Assessment Results

☐ Service Plan

☐ Discharge Information

☐ Other: _____

I also understand that any disclosure made is bound by part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and those recipients of this information may re-disclose it only in connection with their official duties. 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 within one year of the date of this signature:

Expiration date is one year from the date of this signature unless otherwise stipulated here:

Facsimiles provide valid forms of consent

The purpose of and need for this disclosure is:

To make referral, provide on going progress reports, verification of completion of assessment and treatment.

In addition; I give permission to receive messages by email, cellphone TEXT message or voice mail/answering machine to the phone number provided for reminder messages of rescheduled appointments, missed appointments, groups start dates and times.

Client Signature: _____ Date: _____

Witness: Guardian/Legal Rep: _____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION CRIMINAL JUSTICE SYSTEM REFERRAL

42 CFR Part 2 and HIPAA

I, _____, authorize
Patient's Name

_____ to disclose to one another:
Name or general designation of individual or entity making the disclosure

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 or 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.

Signature of Patient: _____ Date: _____

Signature of person signing form if not patient: _____ Date: _____

Describe authority to sign on behalf of patient: _____

Witness/Staff Signature: _____ Date: _____

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 S 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 S 2.12(c)(5) and S 2.65.

ALLIANCE ASSESSMENTS, LLC. SERVICE AGREEMENT

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 provided; and
B) Completing the recommended level of treatment or education at an authorized NC DWI Services Provider.

Provider Choice:

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

A list of agencies in Forsyth county – see next page

Service Level Recommendations:

☐ 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:

☐ I understand that if I have not begun the recommended substance abuse education or treatment to resolve my DWI within 6 months from the assessment date a new assessment and assessment fee will be required.

Complete Driving History:

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

Program Requirements and Fees:

☐ I understand that if I complete the recommended level of care at Alliance Assessments, LLC., these will be the program requirements and fees.

Installment fees must be paid weekly in order to remain in treatment

DWI Assessments $100 for each charge

Short term treatment (20 hours) $350 or $400 if paid in installments ($75 weekly payment)

Long term treatment (40 hours) $700 or $800 if paid in installments ($75 weekly payment)

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

Alliance Assessments may complete a random drug screen, the cost of which is included in treatment fee

Certificate of Completion (E508) Processing:

☐ 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's Signature: _____ Date: _____

Counselor's Signature: _____ Date: _____

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

Client's Signature: _____ Date: _____

Counselor's Signature: _____ Date: _____

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