Alternative Living Solutions of North Carolina
Consent to Receive Treatment

Name: Medicaid #_____ Record Number:_____

AUTHORIZATION FOR TREATMENT/HABILITATION:

I, individually or in my capacity as the legally responsible person for the person receiving services, voluntarily authorize and consent to treatment/habilitation, including, but not limited to, diagnostic, preventative, and therapeutic services by Alternative Living Solutions of North Carolina. I understand this consent shall remain in effect until I notify Alternative Living Solutions of North Carolina in writing that I no longer consent to treatment/habilitation. I understand that no guarantees have been made to me regarding treatment/habilitation. I understand that I should ask questions and/or discuss any concerns with my provider. I understand that I cannot smoke in Alternative Living Solutions of North Carolina facility.

AUTHORIZATION FOR EMERGENCY TREATMENT/HABILITATION:

In case of an emergency, I authorize Alternative Living Solutions of North Carolina to obtain emergency treatment/habilitation from any necessary physician, emergency room, and/or emergency transportation service.

ACKNOWLEDGMENT OF RECEIPT OF FORMS:

I acknowledge the following forms are available on Alternative Living Solutions of North Carolina web page at [www.alternativelivingsolutions-nc.org]: Guide to Rights and Responsibilities, Notice of Privacy Practices, Universal Declaration of Human Rights of the United Nations, and the No Show Policy. If I receive treatment/habilitation through the Local Management Entities / Managed Care Organizations ("LME / MCO") system, I understand that the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services and many of the LME / MCOs publish consumer handbooks related to the treatment/habilitation I will receive from Alternative Living Solutions of North Carolina.

INFORMED CONSENT REGARDING THE USE OF TELEMEDICINE:

Telemedicine is the practice of providing treatment/habilitation using technology between a provider in one location and me in another location. I understand that the provider and I will not be in the same room during treatment/habilitation. I understand there are potential risks to using technology, including interruptions, unauthorized access, and technical difficulties. I understand that my provider or I can discontinue the telemedicine consult/visit if it is felt the technology is not adequate for the situation.

FINANCIALAGREEMENT:

If my insurance does not pay for my treatment/habilitation from Alternative Living Solutions of North Carolina, I am responsible for paying Alternative Living Solutions of North Carolina for the cost of my treatment/habilitation including, but not limited to, co-payments, deductibles, and/or co-insurance. I understand that if any payment I owe to Alternative Living Solutions of North Carolina is not paid within ninety (90) days of the date of service, my account may be turned over to a collection agency. I authorize all insurers or payers, who may be responsible for paying Alternative Living Solutions of

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North Carolina for my treatment/habilitation, to pay Alternative Living Solutions of North Carolina directly.

RELEASE OF INFORMATION FOR PAYMENT:
I authorize Alternative Living Solutions of North Carolina to disclose information related to my treatment/habilitation to insurers and payers for payment purposes. This information includes, but is not limited to, records related to diagnosis, assessment, treatment/habilitation, mental health, drug and alcohol use/abuse, AIDS, and AIDS-related conditions such as HIV. MEDICAID SPECIAL PROVISION If I am a Medicaid beneficiary at time of service, with the exception of applicable co-pays, I am not financially responsible for any services provided by Alternative Living Solutions of North Carolina and not paid by Medicaid. It is my responsibility to present my Medicaid card each month and to inform Alternative Living Solutions of North Carolina of any changes in Medicaid status.

HEALTH INFORMATION EXCHANGE:
Alternative Living Solutions of North Carolina participates in a health information exchange called NC HealthConnex. NC HealthConnex is an electronic network that allows participating medical providers to share your health information with one another. This enables participating physicians, hospitals, laboratories, pharmacies, and other health care providers to have access to important medical information about you that can assist them in making critical medical decisions for you. Your patient record in NC HealthConnex will include information about your medications, allergies, laboratory results, and other information gathered during your encounters from your health care provider. Your record will also include your demographic data to help identify you when you visit different health care providers across the state. Only participating health care providers that have signed contracts with the NC HealthConnex will be able to access your medical information through NC HealthConnex.

CONSENT TO RECEIVE TREATMENT/HABILITATION:
Name: Medicaid_____ Record Number_____

METHODS OF CONTACTING AND FOLLOW UP:
I agree that Alternative Living Solutions of North Carolina may contact me using the contact information that I have on file during and following treatment/habilitation. I understand it is my responsibility to inform Alternative Living Solutions of North Carolina of any changes in my contact information. After my treatment/habilitation is complete, Alternative Living Solutions of North Carolina may contact me to inquire about my condition and satisfaction with services. I consent Alternative Living Solutions of North Carolina for to utilize my contact information on file to keep me informed about Alternative Living Solutions of North Carolina annual reports, advocacy alerts, general updates, and service opportunities that may or may not pertain to my treatment/habilitation by Alternative Living Solutions of North Carolina.

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CONSENT SPECIFIC TO LONG TERM SUPPORT SERVICES FOR MEDICAID CONSUMERS

• I agree to actively participate in all assessments and treatment/habilitation team processes related to my services. I agree to notify team members of my desire for changes in my services or service delivery methods.

• If Alternative Living Solutions of North Carolina serves as my representative payee, I consent for Alternative Living Solutions of North Carolina to apply as my representative payee for my benefits from Social Security. If Alternative Living Solutions of North Carolina is named as payee, all benefits will be sent directly to Alternative Living Solutions of North Carolina.

• I understand that Alternative Living Solutions of North Carolina does not reimburse or replace lost or damaged personal items.

• I understand that excessive absences from receiving services may lead to funding entities questioning the medical necessity of my services and could lead to a reduction in services as authorized by the LME / MCO. When possible, I agree to notify Alternative Living Solutions of North Carolina when I will not be available for services.

• I understand that upon discharge of services, whether voluntarily or involuntarily fortyfive (45) days of discharge. After forty-five (45) days, I understand I will be discharged as a client.

It is understood my signature reflects acknowledgment of the agreement with the above statements. I understand that all permissions may be withdrawn at any time through written notification to Alternative Living Solutions of North Carolina

Name of Person Receiving Services or Legally Responsible Person: **Date:**

_____ _____

Signature of Person Receiving Services or Legally Responsible Person: **Date:**

_____ _____