Eclectic Therapeutic Connections, PLLC
8601 Six Forks Road, Suite 400
Raleigh, NC 27615
(919) 637-4089 office #; (919) 322-8236 crisis#
1-(888)-462-2058 fax

INTAKE PACKET

Today's Date: _____

Client Name: _____ DOB: _____

Primary Insurance Name: _____ Policy #:_____

Secondary Insurance: _____ Policy #: _____

SSN: _____

IDENTIFYING INFORMATION

Home Address: _____ County: _____

Home Phone: _____ School/Grade: _____

Legal Guardian Name/Phone: _____

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

EMERGENCY CONTACT

First Contact: _____ Relationship to Client: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

Physician's Name/Phone: _____

Others in the Home (Names/Relationship to Client/Ages if appropriate): _____

_____

_____

Significant Others Involved with Client: _____

_____

MENTAL HEALTH/BEHAVIORAL INFORMATION

Reason for Seeking Services: _____

_____

Recent Treatment History (last 12 months): _____

_____

Pertinent Medical Issues: _____

_____

Client Medications: _____

Other Active Service Providers (last six months): _____

Court Involvement and/or Pending Charges: _____

_____

Eclectic Therapeutic Connections, PLLC
8601 Six Forks Road, Suite 400
Raleigh, NC 27615
(919) 637-4089 office #; (919) 322-8236 crisis#
1-(888)-462-2058 fax

CONSENTS/RIGHTS INFORMATION

I. Consent for Treatment

I hereby give my consent for **Eclectic Therapeutic Connections, PLLC** to provide mental health services to me/my child. In addition, I have been informed of the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time. I understand that I have the right to refuse treatment without the threat of or termination of services under 10A NCAC 27D .0303.

Client/Parent/Guardian: _____ Date: _____

II. Financial Release

I understand that **Eclectic Therapeutic Connections, PLLC** may use confidential information about me to bill and be paid for services. I hereby consent for **Eclectic Therapeutic Connections, PLLC** to release information to the billing agent, **Integrity Support Services** and its contracted clearinghouse, and/or to the funding source, and for the funding source to release information to **Eclectic Therapeutic Connections, PLLC** and **Integrity Support Services** for this purpose.

Client/Parent/Guardian: _____ Date: _____

III. Permission to Seek Emergency Medical Care

I hereby give consent for **Eclectic Therapeutic Connections, PLLC**, to sign consent for emergency medical care in the event that I am unable to do so for myself. It is understood that **Eclectic Therapeutic Connections, PLLC** will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Client/Parent/Guardian: _____ Date: _____

Eclectic Therapeutic Connections, PLLC
8601 Six Forks Road, Suite 400
Raleigh, NC 27615
(919) 637-4089 office #; (919) 322-8236 crisis#
1-(888)-462-2058 fax

IV. Client Rights/Grievance Policies (See Handout)

I have received and had explained to me the Client Rights handout. **Eclectic Therapeutic Connections, PLLC** gave me this handout and verbally explained my rights as a client.

Client/Parent/Guardian: _____ Date: _____

V. Privacy Rights (See Handout)

I have received and had explained to me the Privacy Rights handout. **Eclectic Therapeutic Connections, PLLC** gave me this handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client/Parent/Guardian: _____ Date: _____

I understand that one of my rights is to be able to choose how I am contacted.
I ***do/do not*** *(please circle one)* give permission for **Eclectic Therapeutic Connections, PLLC** to contact me at work.
Furthermore, I ***do/do not*** *(please circle one)* give permission for **Eclectic Therapeutic Connections, PLLC** to leave voice messages for me at ***home/work/both/neither*** *(please circle one).*

Client/Parent/Guardian: _____ Date: _____

Acknowledgement of Access to First Responder System (See Handout)
I have received the Acknowledgement of Access to First Responder System. **Eclectic Therapeutic Connections, PLLC** provider gave me this handout and verbally explained how to use the system in the event of a mental health emergency or crisis. I understand this system is available to me/my child while receiving **Eclectic Therapeutic Connections, PLLC** and a Crisis Plan will be developed as part of my/my child's Person Centered Plan or Treatment Plan.

Consumer/Guardian: _____ Date: _____

Acknowledgement of Criteria and Procedures for Discharge (See Handout)
I have received the **Eclectic Therapeutic Connections, PLLC** procedures for Discharge. A Turning Leaf Therapy Services provider gave me this handout and verbally explained the criteria and procedures for discharge as **Eclectic Therapeutic Connections, PLLC** client.

Consumer/Guardian: _____ Date: _____

Eclectic Therapeutic Connections, PLLC
8601 Six Forks Road, Suite 400

Raleigh, NC 27615

(919) 637-4089 office #; (919) 322-8236 crisis#

1-(888)-462-2058 fax

Eclectic Therapeutic Connections, PLLC, have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; and the Service Description to the Client/Parent/Guardian of the client to be served.

CEO/Signature: _____ Date: _____