connect.
CENTER FOR WELLNESS, PLLC

INTAKE PACKET

OFFICE POLICIES/TREATMENT CONSENT

connect. would like to welcome you to the agency and is pleased to have you as a patient. We are providing you with this informational letter to help you understand how this office operates. Every effort will be made to treat you with courtesy and respect. Please read this information carefully and write down any questions that you might have so that you can discuss them with your therapist
or office staff.

Below is brief summary of the purpose of each form we have asked you to complete.

- **New Patient Information**: To obtain demographic information, to enroll you to receive services from our office, and is a brief health screening and medical history form to establish an overview of your health status. It also gathers insurance coverage information so we will know how to process insurance claims for benefits.
- **MH/DD/SAS Individual Handbook/Handout:** This booklet is designed to provide you with valuable information about your care and services. This information explains how to access services; discusses Person-Centered Planning process, Crisis Services, Your rights, Your responsibilities and other helpful resources.
- **connect. Center for Wellness, PLLC Policies and Procedures:** Explains your responsibilities pertaining to appointments, financial responsibilities, your records and treatment plan, confidentiality, insurance authorizations, and consent for treatment. It briefly explains your rights to complain or to file a grievance, compliment staff, or make suggestions that will help us serve you better.
- **Notice of Privacy Practices:** Describes how the medical information about you may disclose and how you can get access to this information.
- **Permission to Seek Emergency Medical Care:** This form gives connect. Center for Wellness, PLLC authorization to seek medical care for yourself or your child in the event of a medical emergency.

TREATMENT

Psychological treatment varies depending on the personalities of the psychotherapist and patient, and the particular problems you would like to address. There are many different methods that may be employed use to deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who are actively engaged in the process. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Nonetheless, keep in mind that there are no guarantees of what you will experience and there is a risk that you may feel as though therapy is not the most ideal alternative for you at this time.

As a client, you have the right to refuse treatment or withdraw my consent for treatment at any time. If you choose to withdraw my consent for treatment, you must provide a written statement to **connect. Center for Wellness, PLLC** outlining your request.

APPOINTMENTS

Initial interviews and follow-up therapy visits will last about 45 minutes. Other types of evaluation and testing may involve greater amounts of time. Your therapist will discuss this with you.

As a courtesy and in order to facilitate timeliness of client's being seen, please be on time for your appointment. ***If you are more than 15 minutes late, your appointment will be cancelled.*** You can visit the receptionist to have your appointment rescheduled.

CANCELLATIONS

When you schedule an appointment, that time is reserved specifically for you. Appointment reminder cards are provided whenever subsequent appointments are scheduled at the office. **It is the client's responsibility to remember and keep scheduled appointments. A minimum of 24 hours notice is required if you are canceling or re-scheduling an appointment.**

You will be charged **$45.00** for missed appointments and appointments which are canceled with less than 24 hours notice. In the case of evaluations where multiple hours of testing have been scheduled, you will be charged **$45.00/hour.**

EMERGENCIES

If you need to contact your therapist between sessions, please leave a message with the office or send an email and your communication will be returned as soon as possible. However, keep in mind, your therapist is likely seeing several clients throughout the day and will generally have limited time to answer phone calls or emails. In the case of a life-threatening emergency, you should call "9-1-1" to access emergency medical services. In the case of a mental health emergency, please contact your local county LME Access Call Center.

CONFIDENTIALITY AND RELEASE OF INFORMATION

Information disclosed within sessions and the written records pertaining to those sessions are confidential and will not be released to anyone without the written consent of the client or the parent/guardian, in the case of minors and/or dependent adults, except where your therapist is mandated by law to report otherwise confidential information. Circumstances required by law to be reported are:

1. Patient's who pose an imminent threat of danger to themselves or others.
2. Instances of suspected abuse or neglect of a child (physical, sexual and/or emotional).
3. Instances of suspected abuse or neglect of a dependent adult.

Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from your therapist.

Disclosure of confidential information may be required by your health insurance or workman's compensation carrier, or HMO/PPO/MCO/EAP in order to process your claims. Only the minimum necessary information will be communicated to the carrier. Connect Center for

Wellness has no knowledge or control over what insurance companies do with the information submitted and assumes no responsibility for any actions which result from a third party misusing or re-releasing such information without our office's expressed consent

CLIENTS RIGHTS INFORMATION

In the state of North Carolina basic human rights are defined to be the right to dignity, privacy, and human care. In addition to these basic human rights, when you are receiving publicly funded MH/DD/SA services, you have the right to:

- Access to treatment and care regardless of age, sex, race, color, national origin, disability (including AIDS and related conditions), gender identity, socioeconomic status (i.e., inability to pay for services), sexual orientation, religion, etc.
- Privacy and the expectation that your personal information will be kept confidential (see Notice of Privacy Practices for exceptions)
- Review your medical record including treatment plans, clinical notes, comprehensive assessments, psychological reports, and financial records.
- Receive care in the least restrictive environment suitable to meet your needs
- Be informed in advance of potential risks and benefits of treatment, and to consent to or refuse these services.
- Participate in the development of an individualized, person-centered treatment or service plan
- Be free from mental and physical abuse, neglect, and exploitation
- Be free from unwarranted invasion of privacy
- Be free from the threat or fear of unwarranted suspension or expulsion from services
- Fill out an Advanced Directive, which describes how you wanted to be cared for if you are ever unable to decide or speak for yourself
- File a complaint or grievance if you have concerns that we cannot resolve together within 45 days. You may file a grievance with the offices below:

connect. Center for Wellness, PLLC
3200 Old Chapel Hill Rd.
Durham, NC 27707
919.908.9308
www.connectforwellness.com

Advocacy & Customer Service Section – Division of MH/DD/SAS
3009 Mail Service Center
Raleigh, NC 27699-3009
919.715.3197 or 800.662.7030
www.dhhs.gov/mhddsas

Disability Rights North Carolina
2626 Glenwood Avenue, Suite 550
Raleigh, NC 27608
919.856.2195 or 877.235.4210
www.disabilityrightsnc.org

Notice of Policies and Practices (NPP) to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. ***PLEASE REVIEW IT CAREFULLY.***

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- **"PHI"** refers to information in your health record that could identify you.
- **"Treatment, Payment and Health Care Operations"**
  - ***Treatment*** is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - ***Payment*** is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - ***Health Care Operations*** are activities that relate to the performance and operation of our practice. Examples of health care operations include: quality assessment and improvement activities, business-related matters such as audits and administrative services, and care coordination.
- **"Use"** applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **"Disclosure"** applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained.

An ***"authorization"*** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes.

"Psychotherapy notes" are notes your therapist has made about your conversation during a private, group, joint, or family counseling session, which has been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) We have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If you give us information that leads us to suspect child abuse, neglect, or death due to maltreatment, we must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, we must do so.
- Adult and Domestic Abuse: If information you give us gives us reasonable cause to believe that a disabled adult is in need of protective services, we must report this to the Director of Social Services.
- Health Oversight: The North Carolina Psychology Board has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding, and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: We may disclose your confidential information to protect you or others from a serious threat of harm by you.
- Worker's compensation: If you file a workers' compensation claim, we are required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.

IV. Patient's Rights and Therapist's Duties

Patient's Rights

Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, we will send your bills to another address.

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
Right to a Paper Copy – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically

Therapist's duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
If we revise our policies and procedures, we will post such changes in the office and will provide paper copies of changes upon request.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, please contact our office (919) 908-9308 or send a written complaint to 3200 Chapel Hill Rd, Durham, NC 27707.
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go initially into effect on January 1, 2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting new information in the office waiting room. Hard (paper) copies will be available upon request.

YOUR RECORDS INCLUDE:

- **Treatment plan:** A written treatment plan, based on your individual needs, must be implemented within 15 calendar days of admission. You have the right to treatment in the most normal, age-appropriate and least restrictive environment possible. You have the right to take part in the development and periodic review of this plan. You are entitled to review your treatment plan and to understand how to obtain a copy of it from your therapist or the Medical Records Department.
- **Psychological report** *(when applicable)***:** After completion of psychological testing, consumers are entitled to a psychological report that includes testing results/findings, diagnostic information, conclusions and treatment recommendations.
- **Clinical notes:** Purpose Intervention Effectiveness (PIE) notes must be completed within 24hours of service.
- **Comprehensive Clinical Assessment (CCA):** Are conducted at the 1st session, consumers and /or legal guardians along with the treating clinician will sign and date the documents.

- **Financial Records:** Include services and claims billed, outstanding balances, correspondences to retrieve monies due, accounts sent to collections.

OBTAINING A COPY OF YOUR RECORDS: Clients/legal guardians or consumers requesting a treatment plan is not required to sign a written release of information. Information requested to be sent to a third party must be submitted in writing and/or accompanied by a signed release of information specifying the type of information to be released along with the specific place/person (including contact information) of whom the information is being sent to. The patient/parent/legal guardian must sign and date the documents

- A consumer/LRP may request a copy of the treatment/service plan in writing and submit to their treating clinician;
- A copy of the treatment plan will be provided at the time of development or update and revision.
- A treatment plan will be provided when requested. Please request a copy from Attn: Records Dept. at connect. Center for Wellness, PLLC. This request can be faxed to 919.287.2206, emailed to records@connectforwellness.com; mailed to 3200 Old Chapel Hill Rd., or provided to your treating clinician or the office administrative.

FEES FOR SERVICES:

Please reference this rate schedule as rates will differ depending upon the service(s) being provided. Please note that we have the right to change rates at our discretion; however, you will be notified of such changes within 48 hours of any rate modification. Please be mindful that you may be charged for additional services such as report writing, report summary completion, phone conversations lasting longer than 15 minutes, consultation with other professionals at your discretion, after hours care, emergency, preparation or records treatment summaries, and any time spent completing services at your request. All services are typically covered under insurances. While our office will verify insurance and coverage, it is your responsibility to be aware of insurance benefits and coverage. After informed of no insurance coverage for service requested, it is your responsibility to pay the rate listed below. **NOTE: Sliding Fee discounts are available and based on the 2018 Census poverty guidelines. Determinations for discounts are made using a person's family size and income. Information regarding our fee policy is attached at the end of this document and available on our website at www.connectforwellness.com. *Also, clients with government assisted insurance or not responsible for chargers higher than reimbursement rates. Clients with private insurances must adhere to rules of their deductibles, co-insurance, copayments, etc.**

Services	PhD	MS
Intake/Diagnostic Assessment (Mental Health Exam)	**$275.00 (per session)**	**$225.00**
1st consultation/Therapy Session (60 minutes)	**$180.00**	**$150.00**
Follow up Therapy Session (60 minutes)	**$160.00**	**$125.00**
Reunification Therapy (60 minutes)	**$225.00**	**$175.00**
Group Therapy Session (75 minutes)	**$85.00**	**$75.00**
Psycho-educational Testing	**$1,450.00 (battery)**	**$1,250.00 (battery)**
Psychological Testing (full battery)	**$1,850.00 (battery)**	**$1,650.00 (battery)**
Psychological Testing (half battery)	**$1,050.00 (battery)**	**$850.00 (battery)**
Early Entry Testing	**$675.00**	**$575.00**
Phone Consultation (per 15 minutes)	**$25.00**	**$20.00**
Consultation (per hour)	**$200.00**	**$175.00**
Custody Consultation or Evaluation (per hour)	**$250**	**$200**
Completion of Summary	**$20**	**$15**

Name:
DOB:
Medicaid ID:
Record No.:

3200 Old Chapel Hill Rd. Durham, NC 27707
919.908.9308(o) 919.287.2206(f)
www.connectforwellness.com

Reports		

FINANCIAL AGREEMENT & OFFICE BILLING /INSURANCE POLICIES

***please place a check mark by each item to indicate your understanding and agreement.**

__ 1. I understand that professional services are rendered and charged to the client and not to the insurance company. Not all issues/conditions/problems that are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance.

__ 2. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account. I understand that if my therapist or Connect Center for Wellness is not a participating provider, I will pay for services in full at the time of service. This policy applies to secondary and subsequent plans as well. In HMO, PPO, or IPA assigned insurance, where my provider is a participating provider, my provider agrees to accept the allowable charge determination of my insurance carrier as the full charge, and the client is responsible only for deductibles, coinsurance, in any non-covered services.

__ 3. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.

__ 4. I understand that if my insurance(s) require a referral from my primary care physician, Connect Center for Wellness must have verification of the referral prior to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).

__ 5. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s). I authorize Connect Center for Wellness and its agents to release any information concerning my medical care to my insurance company and any of its agents for purpose of determining benefits payable on my medical related charges.

__ 6. I authorize direct payment by my insurance company(s) to **connect. Center for Wellness, PLLC**, or my attending clinician.

__ 7. I accept ultimate responsibility for payment for the services that my dependent(s) or I receive, whether or not my insurance(s) cover these services. This includes, but is not limited to fees for: clinical services or treatment, failed appointments and/or appointments not cancelled with 24 hours notice, report/letter writing, time spent in court or talking to attorneys on my behalf or the behalf of my dependent(s), telephone conversations longer than 5 minutes, site visits, reading records, longer sessions, travel time, etc.

__ 8. I understand that I will receive a statement if I have an outstanding balance on my account and I am to pay any portion that is my responsibility within 15 days of receipt of a statement. A finance charge of 1% per month may be added to my account if payment is overdue.

__ 9. I understand that there will be a $15.00 service fee for any checks returned by my bank due to non-sufficient funds, closed accounts, etc. I agree to accept full responsibility for such fees. The amount of the returned check, plus the service fee, must be paid within 10 days of written notice.

__ 10. I will notify the Office Manager if any problem arises regarding my ability to make timely payments. If my account is overdue (unpaid) and there is no agreement on a payment plan, I understand that this office can use legal means (court, collection agency, etc.) to obtain payment.

__ 11. I am aware of the office policy of Connect Center for Wellness requiring 24 hours notice to cancel an appointment. I understand that I may notify the office staff or the answering service of my intention to cancel an appointment. I further acknowledge that I will be charged $45/hour for any appointment which my dependent(s) or I fail to keep without providing 24 hours notice.

My signature below represents my consent for treatment with connect. Center for Wellness, PLLC and that I have read, understood and received a service plan documents.

_____ _____
Patient Name (Printed) Responsible Party (Printed)
(If patient is a minor or dependent adult)

_____
Signature of Patient or Responsible Party

____/____/____ Date

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies and that I have received copies of these financial agreements.

_____ _____
Patient Name (Printed) Responsible Party (Printed)
(If patient is a minor or dependent adult)

_____
Signature of Patient or Responsible Party

____/____/____ Date

My signature below signifies that I have received information regarding my consumer rights and that I have received the Notice of Privacy and Practices (NPP).

_____ _____
Patient Name (Printed) Responsible Party (Printed)
(If patient is a minor or dependent adult)

_____
Signature of Patient or Responsible Party

____/____/____ Date

My signature below signifies that I have read and understand documentation in my records and how to obtain copies of records (re: treatment plans, PIE notes, CCAs, reports).

_____ _____
Patient Name (Printed) Responsible Party (Printed)
(If patient is a minor or dependent adult)

_____
Signature of Patient or Responsible Party
____/____/____ Date

CONSENT FOR SERVICES:

I, _____ (consumer/parent/legally responsible person), give my consent for **connect. Center for Wellness, PLLC** 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.

PATIENT INFORMATION

Name:_____ Sex: M F
Last First MI

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Cell Phone: _____ Work _____ Phone: _____ Ext. _____

Title: (Please check one) Mr.____ Mrs.____ Ms.____ Other:_____

Date of Birth: _____/_____/_____ Social Security #: _____/____/_____

Marital Status: Single___ Married____ Separated____ Divorced___Widowed___

What is your relationship to the Responsible Party?
Self ____ Spouse ____ Daughter ____ Son ____ Other (specify)_____

Employer: _____

Occupation: _____

Who referred you to this office?

_____

Primary Care Physician: _____

Contact Info.: _____

Presenting Concern(s): _____

_____

_____

Prior Counseling/Mental Health Treatment (please include service dates and past diagnoses): _____

_____

_____

PRIMARY INSURANCE COMPANY
Insurance Company Name: _____

INSURED (The person who is the policy holder)
Name: _____
Last First MI

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____

Patient's relationship to insured? Self____ Spouse____ Daughter____ Son____
Other (specify) _____

Insured Date of Birth:___/___/___ Sex: M F
Employer: _____ ID/SS# _____
Policy #_____

SECONDARY INSURANCE COMPANY
Insurance Company Name: _____

INSURED (The person who is the policy holder)
Name: _____
Last First MI

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Patient's relationship to insured? Self____ Spouse____ Daughter____ Son____
Other (specify) _____

Insured Date of Birth:___/___/___ Sex: M F
Employer: _____ ID/SS# _____
Policy #_____

Permission to Seek Emergency Medical Care:

In the event of a medical emergency, I _____, give the staff of **connect. Center for Wellness, PLLC** permission to seek medical care for my child or myself. I authorize the agency to administer first aid as needed and to contact.

Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

Additionally, My preferred primary care provider is _____, and their phone number is _____. In the event that my primary physician cannot be reached, the local hospitals (Duke Hospital, UNC Hospital, or Central Carolina Hospital) are acceptable.

Patient/Legal Guardian Signature	Date

Consumer Acknowledgement
24-Hour Behavioral Health Crisis Coverage

In the event of a behavioral health crisis after business hours please call **connect. Center for Wellness, PLLC.** Crisis calls will be returned within **30** 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 **Alexandria Westfall, MA at 919.801.8212** the person/agency with whom there is a written agreement to provide coverage in your provider's absence.

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

Acknowledgement of Receipt of Following Documents:

- MH/DD/SAS Handbook/Handouts
- Connect. Center for Wellness, PLLC
  - Policies and Procedures
  - Financial agreements
  - Service plan
- Notice of Privacy Practices
- Authorization to Disclose Health Information

My signature below signifies that I have read, understood, and received a copy of the documents listed above.

_____ Patient Name (Printed)

_____ Responsible Party (Printed)
(If patient is a minor or dependent adult)

_____
Signature of Patient or Responsible Party

____/____/____ Date

FOR OFFICIAL USE ONLY

We have attempted to obtain written acknowledgment of receipt of the documents listed above but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify) _____