Goldsboro Psychological Services

1700 East Ash Street, Suite 203
Goldsboro, N.C. 27530
919-736-3057 Fax 919-736-3058

Client Information Sheet – Adult

Date_____

PATIENT:

Name: _____ M: F:

DOB: _____ Age: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell: _____

Initial if You Agree to Text Messaging _____

Social Security # _____

Email Address: _____

Marital Status: Single: _____ Married: _____

SPOUSE/PARTNER

Name: _____

DOB: _____ Age: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell: _____

Initial if You Agree to Text Messaging _____

Social Security # _____

Divorced: _____ Cohabiting: _____

Separated: _____ Other: _____

OPT OUT OF TEXT MESSAGE REMINDERS: ☐ YES ☐ NO

Reason for Referral: _____

_____

Referral Source: _____

Agency Contacts: _____

Insurance(s): _____

Insurance Number(s): _____

PEOPLE LIVING IN THE HOME:

Name:	**Relationship**	**DOB/Age**

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NOTICE OF PRIVACY PRACTICES
FINANCIAL AGREEMENT
PATIENT SERVICES AGREEMENT
CONSENT FOR TREATMENT

This notice describes how health and personal information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health and personal information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health and personal information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health and personal information. We must follow the privacy practices that are described in the notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health and personal information that we maintain, including health and personal information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

WELCOME TO OUR OFFICE

This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information before we provide services. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session. We can discuss any questions you have about the procedures at that time. When you sign these documents, they represent an agreement between us. You may revoke these agreements in writing at any time. Revocation will be binding on us unless we have taken action in compliance with it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Our first few sessions will involve an evaluation of your needs. You will be seen by me and may also be evaluated by other members of our clinic. By the end of the evaluation I will be able to offer you some first impressions of what our work will include. I encourage you to evaluate this information along with your own opinions and impressions, and should you have questions about any of our services we can discuss them at any time.

MEETINGS

I will usually schedule weekly to bi-weekly sessions, but based upon the type, frequency, length and time of service your schedule may vary. Once an appointment is scheduled you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

PROFESSIONAL FEES

Our customary hourly fee will be explained to you at the time of intake. In addition to individual appointments I may charge for other professional services you may need, which may include report writing, telephone conversations, consulting with other professionals, preparation of records or treatment summaries, or time spent performing additional services at your request. If you become involved in legal proceedings that require my participation I/or my office manager will discuss what my participation will entail, and we will draft an agreement. All charges will be explained to you in writing. Any Court appearances or professional fees that take Dr. Young away from her patients (i.e. phone conferences with lawyers, judges, or court appointed mediators) needs to be paid in full at $250/hr with a maximum of 9 hrs and a minimum of 1 hr. Any travel costs associated need to be compensated at the full price. Mileage shall be paid at the going rate of $0.56/mile. **If we have to cancel a whole day of patients - This amount will need to be paid up front. Please make checks Payable to Goldsboro Psychological Services. This is non-negotiable as we have had to cancel an entire day of patient care at our expense. Any missed appointments or appointments not canceled within 24 hours will incur a fee of $75.00. This will NOT be covered by your insurance and will have to be paid before any other appointments are scheduled and the client can be seen.**

CONTACTING ME

During my work schedule I am generally not available by telephone. When I am unavailable all calls are answered by my office staff or voice mail. I will make every effort to return your call as soon as possible. If you are difficult to reach please inform us of times when you will be available. If you are unable to reach me and feel you can't wait for me to return your call, please contact your primary care physician or the nearest emergency room and ask for the physician on call. If I am unavailable for an extended period of time I will provide you with the name of one of my associates to contact in an emergency.

Client Name: _____ ...edical Record #: _____

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist/doctor. In most situations we can only release information about your treatment if you provide written Authorization that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide advance written consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may find it helpful to consult other healthcare and mental health professionals about your case. During consultations I make every effort to avoid revealing the identity of my patients, and the other professional with whom I consult are also legally bound to keep the information confidential.
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases I share PHI with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Staff are bound by the aforementioned rules of confidentiality. All staff members have received training to protect your privacy and are bound by aforementioned rules of confidentiality.
- I also have business contracts. As required by HIPAA, I have formal business associate contracts with these businesses that require they also maintain the confidentiality of your PHI except as specifically allowed in the contract or otherwise required by law.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If I believe that a patient presents an imminent danger to his/her health or safety I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- I will also obtain an authorization from you before using or disclosing:
- PHI in a way that is not described in this Notice.
- Psychotherapy notes
- PHI for marketing purposes
- PHI in a way that is considered a sale of PHI

There are some situations where I am permitted or required to disclose information without either your consent or Authorization.

- If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim and my services are being compensated through worker's compensation benefits, I must provide a copy of the patient's record to the patient's employer or the North Carolina Industrial Commission.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have cause to suspect that a child under 18 is abused or neglected, or if I have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that I file a report with the County Director of Social Services. Once such a report is filed I may be required to provide additional information.
- If I believe that a patient presents an imminent danger to the health and safety of another I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or Medical Examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep PHI about you in your Clinical Record. Due to the nature of these records they can be misinterpreted and/or upsetting to untrained readers. For this reason, should you wish to review your records I recommend that you have them forwarded to another mental health professional to assist in interpreting the contents. If, in my professional opinion your PHI does not present a danger to yourself and/or others or the records do not make reference to another person, you may examine your clinical record if you provide an advanced written request.

PATIENT RIGHTS AND BILL OF RIGHTS

HIPAA provides you with new and expanded rights that includes the right to amend your record; request restrictions on what information from your Clinical Record is disclosed to others; request an accounting of disclosures of PHI that you have neither consented to nor

authorized; have any complaints you make about my policies and procedures recorded in your records; and the right to obtain a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Right to Opt out of Fundraising Communications. You have a right to decide that you would not like to be included in fundraising communications that I may send out.

Right to Refuse Treatment. Clients have the right to refuse treatment as described in the statute without threat or termination of services except as outlined in the statute. Consent for treatment may be withdrawn at any time.

Right to Treatment. Right to individualized (written)treatment, including access to psychological care and habilitation, regardless of age or degree of MH/IDD/SA disability.
Good healthcare delivery depends upon the cooperative relationship between you and your Provider, as well as between you and Goldsboro Psychological Services.

I. Information Disclosure - You have the right to receive accurate and easily understood information about your health plan, healthcare professionals, and healthcare facilities. If you speak another language, have a physical or mental disability, or just don't understand something, assistance will be provided so you can make informed healthcare decisions.

II. Choice of Providers and Plans - You have the right to a choice of healthcare providers that is sufficient to provide you with access to appropriate high-quality healthcare.

III. Access to Emergency Services - If you have an emergency or sudden illness that convinces you that your mental health is in serious jeopardy, you have the right to receive screening and stabilization emergency services whenever and wherever needed, without prior authorization or financial penalty.

IV. Participation in Treatment Decisions - You have the right to know all your treatment options and to participate in decisions about your care. Parents, guardians, family members, or other individuals that you designate can represent you if you cannot make your own decisions.

V. Respect and Nondiscrimination- You have a right to considerate, respectful and nondiscriminatory care from your doctors, health plan representatives, and other healthcare providers.

VI. Confidentiality of Health Information - You have the right to talk in confidence with your providers and to have your healthcare information protected.

VII. Complaints and Appeals - You have the right to a fair, fast, and objective review of any complaint that you may have against your health plan, providers, hospitals or other healthcare personnel. This includes complaints about waiting times, operating hours, the conduct of healthcare personnel, and the adequacy of healthcare facilities. You have the right to ask for limits on PHI we use and share. We do not have to agree. If we agree, we must follow the limits. We do not have to follow limits to care for you in an emergency. We may cancel our agreement to your limits if we let you know in writing.

VIII. Right to Refuse - Clients have the right to refuse treatment without threat of termination of services unless the procedure is the only viable treatment/habilitation option available at the facility. G S § 122C-57. Consent may be withdrawn at any time by the person who gave the consent. If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible. If all appropriate treatment modalities are refused, the voluntarily admitted client may be discharged.

IX. Right to request restrictions on uses and disclosures - You have the right to ask for limits on PHI we use and share. We do not have to agree. If we agree, we must follow the limits. We do not have to follow limits to care for you in an emergency. We may cancel our agreement to your limits if we let you know in writing

MINORS & PARENTS/GUARDIANS - While privacy in treatment is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information be shared with parents. It is also our policy not to treat a child under 18 years of age without parental consent. It is also our policy not to treat a child under 18 years of age unless he/she agrees that I can share whatever information I consider necessary with his/her parents. Parent/Child signatures at the end of this patient services agreement serve as consent. Before giving parents any information, however, I will discuss the matter with the child and do my best to handle any objections they may have.

Client Name: _____ Medical Record #: _____

Breach Notification Addendum to Policies & Procedures - When the Practice becomes aware of or suspects a breach, as defined in Section 1 of the Breach Notification. Overview, the Practice will conduct a Risk Assessment, as outlined in Section 2.A of the Overview. The Practice will keep a written record of that Risk Assessment. Unless the Practice determines that there is a low probability that PHI has been compromised, the Practice will give notice of the breach as described in Sections 2.B and 2.C of the breach notification Overview. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

BILLING AND PAYMENTS - You will be expected to pay all **non-covered** charges each session at the time of your appointment in the amount of **$185.00 for Diagnostic Intake**and **$150.00 every session thereafter**. **Psychological Testing is $150.00 per session** and if your insurance will not cover it, then it will have to be paid up front or payment arrangements will need to be made at the office managers discretion. Any insurances that have a Primary insurer that is NOT In-Network and therefore the Secondary will NOT pay – Clients WILL be responsible for ALL balances owed by the company. Payment schedules for other professional services will be discussed when they are requested. In circumstances of unusual financial hardship I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary the costs will be included in the claim.

INSURANCE REIMBURSEMENT/MEDICAID - In order for us to set realistic treatment goals and priorities it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide coverage for mental health treatment. We will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, if you have insurance coverage, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage call your plan administrator. If it is necessary we are willing to call the company on your behalf. You should also be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations I will make every effort to release only the minimum information about you that is necessary for the purpose requested. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. By signing this Agreement, you agree that I can provide requested information to your carrier.**YOUR RIGHT TO SEEK EMERGENCY MEDICAL CARE FROM A HOSPITAL OR PHYSICIAN**

Consent that grants permission to seek emergency medical care from a hospital or physician shall be obtained from the individual or legally responsible person.

MINORS

A minor may seek and receive periodic services from a physician without parental consent in accordance with G. S. § 90-21.5.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES, FINANCIAL AGREEMENT, BILL OF RIGHTS, PATIENT SERVICES AGREEMENT,CONSENT FOR TREATMENT FORM DESCRIBED ABOVE. YOUR SIGNATURE ALSO SERVES AS CONFIRMATION THAT YOU HAVE READ AND UNDERSTAND YOUR RIGHTS AS A CLIENT IN THIS FACILITY.

_____

Sign Above Acknowledging that you read our Financial Agreement above

_____

Patient **Date**

_____

Parent/Guardian if Patient is a Minor **Date**

If at any time you want to revoke your agreement, you may do so by contacting our office at 1700 E. Ash Street, Suite 203 Goldsboro NC 27530 or 919-736-3057. Thank you.

Goldsboro Psychological Services

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Goldsboro Psychological Services by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Goldsboro Psychological Services, Alisa R. Young PsyD to:

_____ release to:
_____ obtain from:
_____ exchange with:
Name Of Organization:_____
Name Of Organization:_____
Name Of Organization:_____
Name Of Organization:_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____
_____Treatment Plan (All Patients have a right to their treatment plans)

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

NOTE: The records listed below have special protection by law. I authorize the release of information pertaining to: The diagnosis or treatment of AIDS, including results of HIV tests	□ Yes □ No/NA
The diagnosis or treatment of drug and/or alcohol abuse	□ Yes □ No/NA

Confidential information regarding a client with Substance abuse or HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S. 130A-143. Whenever authorization is required for the release of this information, the consent shall specify that the information to be released includes information relative to Substance Abuse, HIV infection, AIDS or AIDS related conditions

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____(Ask for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ **Name of Client (Print)**

_____ **Date Of Birth**

_____ **Signature of Client/Legally Responsible Guardian**

_____ **Date of Signature**

_____ **Goldsboro Psychological Services Representative**

_____ **Date Of Signature**