



Patient Information

Today's Date: _____ Referred by: _____
 May We thank the person that referred you? _____

Patient's Name (Last, First, Middle) _____ Age _____ DOB _____

Home Address: Street _____ City _____ State _____ Zip Code _____

Mobile Phone _____ Email Address _____

Home Phone _____ Social Security Number _____ Marital Status _____

Patient's Employer _____ Occupation _____ How Long Employed? _____

Employer's Address _____ Phone Number _____

Spouse (or responsible party) _____ Social Security Number _____

Full Name of Children (in Birth date order):
 Name _____ Age _____

Others Living in Home _____ Relationship _____

Personal Physician _____ Address _____ Phone _____ Date of Last Exam _____

Current Therapist _____ Address _____ Phone _____

List All Medications Currently Taken _____

Have you been hospitalized in the last 5 years? If so, for what reason?

Have you had previous psychological or psychiatric treatment? Where and when?

Has any family member been seen previously by our office? If yes, when?

Insurance Carrier _____ Policy Holder _____ ID number _____ Group number _____

Insurance Authorization and Assignment (Please Read and Sign):
 I hereby authorize Southlake Counseling and Consulting and Southlake Center for Self Discovery to furnish information to insurance carriers listed above concerning my illness and treatments. I hereby assign to the physician/clinician all payments for medical services rendered to me. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

 Signature of Responsible Party _____ Date _____



PATIENT RIGHTS AND RESONSIBILITIES

Welcome to our Office

CONFIDENTIALITY

Privacy and confidentiality are of the utmost importance to the clinical relationship. Information given by the client remains private and confidential. The therapist will not share information with any person without your written permission, except as required by law or in a situation deemed potentially life threatening. I grant permission to the therapist to communicate with my emergency contact person if a situation is deemed potentially life threatening.

FINANCIAL

Insurance information needs to be current and accurate. You are expected to pay all deductibles and co-payment amounts at the time of each visit. Clients are responsible for the payment of all applicable fees at the time of each visit. If you are the parent or guardian of a minor, all costs not covered by your insurance company will be your responsibility. **The office does not become involved with division of accounts between divorced parents.**

APPOINTMENTS

Appointments are scheduled as a forty-five minute therapeutic hour. In the event that you must cancel an appointment, please call (704) 896-7776 at least 24 hours, preferably 48 hours in advance. Failure to give 24 hour notice will result in your being billed in full for that session. Insurance companies will not reimburse for missed appointments.

MANAGED CARE CLIENTS

Most managed care plans require pre-approval for mental health services. Noncompliance could lead to denial of benefits (payment for services). If you have entered therapy with this office under a managed care plan, please verify prior approval for services. Under some managed care plans, the therapist is required to provide clinical information to a case manger after the initial session if additional sessions are needed. If you have any questions about this procedure, please speak to the therapist.

Signature

Date



In Case of Emergency

The Southlake Center for Self Discovery and Southlake Counseling and Consulting are not medical facilities. Therefore, we only admit participants that are physically safe. For this reason, we ask that you see a physician for blood work (Biochemical Profile and CBC) and that you consent to the following policy. During treatment, some patients have suicidal, self-harm or homicidal thoughts. These generally pass within hours or days if discussed in sessions. You may call the Center at any time during working hours and leave a message for your primary therapist who will make every effort to call you back before the end of the day. If you have an emergency after hours (5:30 pm- 9:30 am) or on the weekend, you may leave a message with Kimberly Krueger at 704-896-7776.

Please read the following contract, which is required of all individuals being treated on an outpatient basis at The Southlake Center for Self Discovery and Southlake Counseling and Consulting:

1. I promise to talk with my individual therapist if I should have any thoughts of harming myself or someone else. I understand that for some individuals, these thoughts may be a natural part of the therapy process and are likely to pass if I talk about them.
2. I understand that the ultimate responsibility for my health and therapy is my own. Therefore, I agree to give my therapist 48 hours to respond to my call. In the interim, I may phone a hotline for support or go to an emergency room if unable to keep myself safe.

I have read and understand the emergency policies and promise to abide by them.

| | | | |
|-------------------|------|---------|------|
| Patient Signature | Date | Witness | Date |
|-------------------|------|---------|------|

| | | | |
|----------------------------|------|---------|------|
| Parent/ Guardian Signature | Date | Witness | Date |
|----------------------------|------|---------|------|



Insurance and Financial Policies

709 Southeast Drive Suite 20, Davidson, NC 28036
704-896-7776 phone 704-896-0992 fax

Health insurance is a contract between you, your employer and your health insurance company. Each policy has different rules regarding which services are allowed, deductible amounts, how you are charged, where lab work is sent, etc. You are responsible for knowing the terms of your health contract benefits. We need all of the information on the attached demographics sheet as well as a copy of your insurance card(s). Be sure to give us your primary AND secondary cards if applicable. If the time frame for submission of a claim lapses due to incorrect information, you are responsible for those fees.

Prior approval is required for most mental health treatment. You are responsible for getting the initial authorization number. If you have it, and have not already called it in to us, please provide it to the receptionist. If not, we will ask that you use our phone to get that number PRIOR to being seen. Additionally, some policies require that your Primary Care Physician refer you to us. In those cases, you must be certain that he/she knows to send us such referral. We must have such referral in hand before we can proceed. **YOUR FAILURE TO OBTAIN THE PROPER REFERRAL OR INITIAL AUTHORIZATION WILL MAKE YOU FULLY RESPONSIBLE FOR OUR FEES.** You may be limited by your policy in the number of mental health visits per year allowed or you may have a dollar limit ("cap").

At the time of service, deductible, co- payments and/or your percentage of fees are payable. Any balance due after your insurance company pays or denies your claim is payable BY YOU when billed.

If we have to use an outside agency to collect the balance on your account or obtain current address, insurance information, etc., and administrative fee will be billed to your account.

1. Telephone calls to clinicians may be subject to a \$10 minimum charge.
2. Pharmacy call-ins may be subject to a \$10 charge, if authorized by your psychiatrist.
3. Processing time/paperwork with your insurance to obtain non-formulary medication authorizations is subject up to a \$20 charge.
4. Form letters, reports, etc. are subject to an administrative charge.
5. Missed appointments not cancelled 24 hours in advance will be charged to you AT FULL FEE even if you did not receive a reminder call.
6. Payment is due at the time of service, unpaid fees/co-payments will be assessed a \$3.00 surcharge.
7. Any involvement in court procedures, depositions, or testimonies are billed at \$250.00 an hour.

Please remember YOU, not your Doctor, are the policyholder. If your insurance fails to pay on a timely basis, (within 90 days), we will send you a Statement of Account notifying you that your claim is unpaid, at which time you/your employer must assist in pursuing your benefits.

Your signature below indicates that you fully approve and understand the above.

Signature _____ date _____



ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Main Office: 709-20 Northeast Drive
Davidson, NC 28036
(704) 896-7776

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my health care providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information (PHI). I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my health care provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that *Southlake Counseling and Consulting* and *The Southlake Center for Self Discovery* restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, and I understand that *Southlake Counseling and Consulting* and *The Southlake Center for Self Discovery* are not required to agree to my requested restrictions. If *Southlake Counseling and Consulting* and *The Southlake Center for Self Discovery* do agree, then *Southlake Counseling and Consulting* and *The Southlake Center for Self Discovery* are bound to abide by such restrictions.

Patient Name _____ Date _____

Signature of Responsible Party _____

Relationship to Patient _____

Dependent family members also covered by this acknowledgement: _____

For Office Use Only

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

___The patient refused to sign ___Emergency situation

___Communication barriers ___Other: _____



**Notice of Privacy Practices
Under the Health Information Portability & Accountability Act
H.I.P.A.A.**

The effective date of this Notice of Privacy Practices is August 15, 2003.

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

As part of our services, we maintain personal information about you and your health. State and federal law protects such information by limiting its uses and disclosures. "Protected health information" (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present, or future physical or mental health or condition, the provision of health care services, or the past, present, or future payment for the provision of health care. The confidentiality of alcohol and drug abuse patient records is also specifically subject to additional restrictions under other state and federal law. We are required to comply with these additional restrictions.

Your Rights Regarding Your PHI: The following are your rights regarding PHI that we maintain about you:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in certain limited circumstances, to inspect and copy your PHI that we maintain. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request a copy of the required accounting of disclosures that we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you in a certain way or at a certain location. We will accommodate reasonable requests and will not ask why you are making the request.
- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice.
- **Right of Complaint.** You have the right to file a complaint in writing with us or with the Secretary of Health and Human Services if you believe we have violated your privacy rights. *We will not retaliate against you for filing a complaint.*

Our Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations:

Treatment: We may use your PHI for the purpose of providing you with health care treatment. To coordinate and manage your care, we may disclose your PHI to others of your current providers. We may also disclose your PHI to other health care providers who become involved in your care.

Payment: We may use your PHI in connection with billing statements we send you and our system for tracking charges and credits to your account. In addition, but with your authorization, we may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability, as well as to submit claims for payment and medical necessity and utilization reviews.

Health Care Operations: We may use and disclose your PHI for the health care operations of our program in support of the functions of treatment and payment. Such disclosures would be to a Qualified Organization only or to a Business Associate/ QSO (Qualified Service Organization) to provide services to the program and its patients for data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect.

(Continue on Next Page)



Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object:

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. For example, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Audit and Evaluation: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations performing utilization and quality control. If we disclose PHI to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your PHI.

Medical Emergencies: We may use or disclose your PHI in a medical emergency situation to medical personnel only.

Child Abuse or Neglect: We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Research: We may disclose your PHI for use in a research project that an Institutional review board has determined to be of sufficient importance to outweigh the privacy intrusion, to be impractical without PHI, to have specified safeguards against further disclosure in reports or otherwise, and, among other provisions, to require destruction or de-identification of your PHI.

Criminal Activity on Program Premises/Against Program Personnel: We may disclose your PHI to law enforcement officials if you have committed a crime on program premises or against program personnel or you have made a threat to commit such crimes. Such disclosure is limited to circumstances of the incident, including name, address, status as a patient, and last known whereabouts.

Qualified Service Organization: We may disclose your PHI to a Qualified Service Organization to provide certain services to the program and its patients, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy. If a QSO has more than will be utilized, otherwise only a Qualified Service Organization Agreement will be used. In the case the services is from a health care provider performing services to treat you, a Business Associate Agreement will not be utilized because you will have a direct patient-provider relationship.

Court Order: We may disclose your PHI if a court of competent jurisdiction issues an appropriate order.

Uses and Disclosures of PHI With Your Written Authorization:

We will make other uses and disclosures of your PHI only with your written authorization. You may revoke this authorization in writing at any time, unless we have taken a substantial action in reliance on the authorization such as providing you with health care services for which we must submit subsequent claim(s) for payment.



Consent for Counseling Services to Minors

In order for minor children/adolescents to receive psychological services, it is necessary for the parent or legal guardian to grant permission for such services to occur.

Names and date of birth of child(ren) to receive psychological services:

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name of person requesting services: _____

Your relationship to child(ren): Parent Stepparent Guardian Grandparent Other

Are you legal parent or custodian to above-named children? Yes No

I hereby swear that I have legal right to obtain treatment for the above-named children: Yes No

In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order which names you the legal custodian of the above children.

Are you willing to do so? Yes No

If the answer to any of the above questions is "No", counseling services can not be provided to the above-named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.

I acknowledge that both natural parents, even though divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the child(ren).

- North Carolina State law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.
- This treatment may also include referral to other appropriate State and County agencies for further counseling.

I, _____, consent to _____, a provider at Southlake Counseling and Consulting & Southlake Center For Self Discovery, in providing psychological services to the child(ren) named above.

These services may include () Clinical services; () Counseling/Psychotherapy; or () Other services

Signature of person authorizing consent Date

Rev. August 1, 2007



PARENTAL AGREEMENT FOR CONFIDENTIALITY OF ADOLESCENT SESSIONS

Dear Parent or Guardian,

A young person is more likely to disclose sensitive information to a counselor if he or she is provided with confidential services and has time alone with the counselor to discuss his or her issues. The most practical reason for clinicians to grant confidentiality to an adolescent client is to facilitate accurate and appropriate treatment.

Experienced clinicians recognize that candid and complete information can be gathered only by speaking with the adolescent patient alone and by clarifying with whom the information will be shared. If an assurance of confidentiality is not extended, this may create an obstacle to the safe environment of the counseling relationship.

Some areas of teenage health that we may talk about during the appointment are:

- Diet, exercise, and body image
- Fighting, danger, and violence
- Sexuality and sexual behavior
- Safety and driving
- Smoking, drugs, and alcohol
- Working/Jobs
- Depression and stress
- Peer pressure and school
- Relationships
- Family life

Professionals at *The Southlake Center for Self Discovery* and *Southlake Counseling and Consulting* encourage teenagers to share information about their emotional and mental health with their parents or guardians. However, there will be some things that your teenage son or daughter would rather talk about exclusively with a counselor.

Work with an adolescent is generally more productive if parents voluntarily agree to not request information about the adolescent's private session. Professionals at *The Southlake Center for Self Discovery* and *Southlake Counseling and Consulting* ask your permission to keep what is discussed in our sessions confidential. "Confidential" means professionals at *The Southlake Center for Self Discovery* and *Southlake Counseling and Consulting* will only share information with you if your teenage son or daughter says it's alright. The counselor agrees to share with the parent(s) any information which is necessary for the safety of the adolescent.

I agree that the therapist will determine what information, in his or her professional judgment, is appropriate to be shared with the parent/guardian(s) concerning treatment issues, and what information, in the discretion of the therapist will remain confidential between my adolescent child and the therapist.

Parental/Guardian Agreement Date

Witness Date