

INSTRUCTIONS TO CLIENTS PRIOR TO FIRST SESSION

If you are using health insurance, you will need to call your carrier and ask the following five questions prior to your first session.

- 1) Do you need pre-authorization? Call your insurance carrier. There may be a special phone number on the back of your card specifically for mental health or behavioral health services. Get the authorization number if one is required. Get the start date of the authorization. Get the number of sessions you have been authorized for, and get the expiration date if applicable, Get the name and location of the individual that you talk to.
- 2) Is there a deductible? How much is it and has any been met? Again, get the name and location of the individual that you speak to.
- 3) What is your co-payment or co-insurance amount? It may be a specific dollar amount, or it may be a percentage. This, along with any deductible no met will be the amount due at the time of service.
- 4) How many sessions are you allowed per year? Does your plan run with the calendar year, or do they use a different fiscal year? Have you seen other mental health professionals this year? If so, how many sessions do you have left?
- 5) Does your employer provide an Employee Assistance Program (EAP)? If you have and EAP benefit , you will need to obtain information about which EAP you will be using. You will need the same information as above. Number of sessions, authorization number, beginning and expiration date, if any. There can be several addresses for the same product, so please be able to provide your therapist with the address that is used to request payment for your services.

If your yearly deductible has not been met, your insurance carriers allowed amount (contract rate) is due from the client at the time of service. We take cash, checks money order, Visa, MasterCard, Discover and Flex Plan cards.

If any amount is paid by a third party (ie: Cigna or ValueOptions, instead of Blue Cross Blue Shield if it's a BCBS card), we will need that claims address and you will need to call the Mental Health-Substance Abuse number on your card for per-authorization, and provide your therapist with the pre-auth number and claims address.

At your first session, we require that the financially responsible adult provide us with their social security number, date of birth and photo I.D. If you are using insurance, we will also need a copy of your insurance card and the employers name.

Carolina Psychological Associates, P.A.
5509-B West Friendly Avenue
Suite 106
Greensboro, N.C. 27410-4249

Today's Date: _____

Name of Child: _____

Name he/she is called: _____ Gender: _____ Age _____

Date of birth : _____ S.S. # _____

Parent Information, please check:

Single _____ Married _____ Partnered _____ Separated _____ Divorced _____ Widowed _____

If divorced, who has legal custody? _____

If custody, sole custody or joint custody? _____

Child lives with: Both parents _____ Mother _____ Father _____ Foster parents _____

Father (Stepfather) Name: _____ DOB: _____

Address: _____

(City) _____ (State) _____ (Zip Code) _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Occupation: _____ S.S.# : _____

Place of Employment: _____

Mother (Stepmother) Name: _____ DOB: _____

Address: _____

(City) _____ (State) _____ (Zip Code) _____

Home Phone: _____ Business Phone _____ Cell Phone: _____

Occupation: _____ S.S.#: _____

Place of Employment: _____

Person responsible for payment: _____

Relationship to minor: _____

Address: _____

The financially responsible adult is the person who signs the consent for services.

Name of person/professional referring you to me: _____

When did your child's problems/symptoms begin? _____

Please list those (other than parents) living in the home:

Name	Age	Relationship (sister, uncle, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list other family member no longer living in the home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any unusual health problems the child has: _____

Is the child taking any prescribed medications? Yes _____ No _____

If yes, list medication(s) and prescriber here: _____

Does child have problems with vision? _____ hearing? _____ If yes, explain: _____

Have you talked to other people (doctor, minister, etc.) or agencies (social services, public health, etc.) about this problem? Yes _____ No _____

School your child attends: _____ Grade: _____

Teacher: _____ Has your child been seen by any of these specialists

in school? (please check): School Psychologist _____ Speech Therapist _____ LD Teacher _____

Check those items which apply to your child:

DISCIPLINE

_____ Will not do as he/she is told

_____ Has temper tantrums

SOCIAL BEHAVIOR

_____ Is excessively shy

_____ Loses temper easily

_____ Has been caught cheating or stealing

_____ Tells lies

_____ Cannot be quiet or sit still, even for short periods of time

_____ Is disruptive in school and at home

SUBSTANCE ABUSE

_____ Uses illegal drugs

_____ Use alcohol or cigarettes without parental permission

MOOD AND SELF IMAGE

_____ Is anxious and worries a lot

_____ Has unusual fears—of what? _____

_____ Cries easily

_____ Has poor self image, thinks of him/herself as dumb, ugly or unloved

_____ Conceited, has overly high opinion of self, thinks he/she is better than others

_____ Talks about suicide

HEALTH

_____ Complains of frequent pains—where? _____

_____ Frequently complains of being sick for no apparent reason

_____ Problems with appetite: eats too little _____ or too much _____

_____ Has difficulty sleeping

_____ Wets or soils self

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EMPLOYEE ASSISTANCE PROGRAMS AND MANAGED CARE SERVICES

PLEASE READ AND SIGN:

I give my consent for psychological services to be provided to me and/or my child,
_____ **by CAROLINA PSYCHOLOGICAL ASSOCIATES, P.A.**

I understand that my sessions with Carolina Psychological Associates have been either authorized through my EAP or approved through a Managed Care Insurance program. This may mean that I can be seen either free of charge to me, or at reduced rates and/or copayments. I agree to pay all appropriate copayments as well as applicable deductibles and for services disallowed for any reason by my EAP/MC program or insurance company. I may or may not be financially responsible for appointments missed or canceled without 24 hour advance notice. I understand that I will forfeit my allotted EAP session(s) for each appointment missed or canceled without 24 hour advance notice. I agree that if I pay by check, my account will be debited electronically for both the face amount and returned check fee (\$25.00) if it is returned unpaid. I also understand that I am financially responsible for any collections fees/court costs involved in collecting my past due account. I understand that if I am unable to keep a scheduled appointment, that I will notify Carolina Psychological Associates with at least 24 hour advance notice. I understand that I am financially responsible for all phone calls longer than 15 minutes.

Payment is required at the time service is provided; however, insurance information will be obtained at the first session and insurance will be filed as a courtesy to me for sessions following the initial EAP sessions. Psychological testing and hospitalization are not covered by EAP's.

Release and Assignment: I hereby authorize any plan benefits to be paid directly to Carolina Psychological Associates, P.A., and I understand that I am financially responsible for non-covered services, including those for which authorization or payment has been denied, either by my EAP/Managed Care plan or other payor. If a claim is made by me or Carolina Psychological Associates to any insurance company or companies, or to any other third party payor, I do not object to the release by mail, fax, telephone or computer modem, any records or other information about me, or my child, or the services which are provided, including without limitation, the complete case record, information concerning any personal, psychological and medical history, information concerning diagnosis and treatment by Carolina Psychological Associates, and information concerning billing and payment for such services. I agree that all such information shall be subject to review by such insurance company or third party payor during the period of my or my child's treatment by Carolina Psychological Associates or at any other time thereafter.

If the parents of a child are separated or divorced and there is joint custody, I understand and consent to the other parent's notification of treatment of my child as advised by the N.C. Attorney General's office.

Your signature below indicates that you have read this agreement and understand and agree to its terms, it also serves as acknowledgment that you have reviewed the HIPAA Booklet that contains the NC Notice Form, the Psychologist-Patient Services Agreement and the Patients Rights and Responsibilities. You may request a copy of these notices.

Client or Parent/Guardian Signature

Date

PRINT Your Name Here

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CELLULAR PHONE AND FAX COMMUNICATION FORM

I give my consent for Carolina Psychological Associates, P.A., to send by electronic transmittal or communicate by cellular phone, with appropriate release of information, confidential information concerning my or my child's diagnosis, care, testing records, treatment plan and goals. I am fully aware that electronic transmittal and wireless telephone communication is subject to difficulties. I understand that Carolina Psychological Associates, P.A., will exercise all reasonable precautions, and I will in no way hold Carolina Psychological Associates, P.A., liable for any difficulties resulting to me or any other family member from the communication of confidential information by means of fax or cellular phone.

Client Signature

Date

Parent or Guardian Signature

Date

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FEE INFORMATION

Fees are an important issue to anyone receiving professional services. This fact sheet has been prepared to clarify our policies.

FEES: Our usual and customary fees are **\$140.00** for an initial Intake, **\$120.00** per 50 minute session of psychotherapy, and **\$130.00** per hour of psychological testing. Fees for psychological testing are based on time spent with the client, *plus time spent for interpretation of results and report writing*. Payment is requested at the time services are rendered, by check, cash, money order, Visa, MasterCard, Discover or Flex Plan cards.

INSURANCE: As a courtesy, we will file your insurance for you. However, the client is expected to pay for non-covered services and deductibles, as well as co-payments, at the time services are rendered. If insurance payment is not received within **90 days**, after a claim is filed, the client will become responsible for payment of the total amount due. **It is your responsibility to follow-up with your insurance carrier for delayed payments or other concerns.**

BILLING: We will bill clients monthly after insurance has been filed. This is a reminder of your balance due and is an informational statement to keep you up-to-date regarding the status of your account. Our usual and customary collection procedures will be followed in order to collect unpaid balance and co-payments due.

REFUNDS ARE ISSUED ONCE A MONTH, ONLY AFTER ALL PENDING INSURANCE CLAIMS HAVE CLEARED.

PAST DUE ACCOUNTS: Processing past due accounts is expensive. Accounts which are over three months past due may be assigned to our collections attorney or small claims court, depending upon the total balance due, for enforcement of collection.

MISSED APPOINTMENTS: IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE NOTIFY OUR OFFICE IMMEDIATELY. IF AN APPOINTMENT IS CANCELED OR MISSED WITHOUT 24-HOUR ADVANCE NOTICE, YOU WILL BE CHARGED FOR THIS SESSION TIME. WE HAVE A 24-HOUR-A-DAY PHONE COVERAGE THROUGH OUR OFFICE, WHICH INCLUDES AFTER HOURS VOICE MAIL. INSURANCE DOES NOT PAY FOR MISSED APPOINTMENTS; THEREFORE, YOU WILL BE FINANCIALLY RESPONSIBLE FOR THE FULL FEE.

RESPONSIBILITY: The client (or referring parent in the case of minors) is considered responsible for payment of our professional fee. **It is the client's responsibility to know the amount of their deductible and co-payment.** When we are requested to bill a third party, such as a divorced spouse, relative, or insurance company, and that third party fails to make timely payments, payment is expected from the referring parent that signed the consent for services. The client will be responsible for claims that are denied due to "filing past the insurance carriers time limit", that are the result of failure by the client to inform this office of changes in insurance coverage.

If you have questions or concerns, please discuss them with us. Signing below indicates that you have read, understand and agree with the Fee Information guidelines outlined above.

Client (or parent/guardian) Signature

Date

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INSURANCE INFORMATION

Did you call for Pre-Authorization? NO _____ YES _____ Pre-Auth Number: _____

MANY INSURANCE COMPANIES REQUIRE PRE-AUTHORIZATION FOR MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES. IF THIS IS REQUIRED BY YOUR INSURANCE CARRIER AND YOU DID NOT CALL, BE AWARE THAT YOU MAY BE PENALIZED WITH DENIAL OR REDUCED BENEFITS.

We will gladly file your insurance for you as a courtesy. However, we must have **FULL INSURANCE INFORMATION COMPLETED BELOW**. It is up to the client to know his/her insurance coverage, including knowledge of co-payment amounts and yearly deductibles. We cannot verify this information for you. If payment of the bill has not been satisfied by the insurance company within **90 days**, it is the responsibility of the client or guardian to pay the bill in full. **We will not wait for secondary insurance to pay the balance. Co-payments and deductibles are always due at the time of service.**

Client's Name: _____

Client's relationship to insured: _____

Client's status: Single _____ Married _____ Widowed _____ Partnered _____ Other _____

Employed _____ Full time student _____ Part time student _____

Insured's Name: _____

Insured's Address: _____

City _____ State _____ Zip _____

Insured's Social Security Number: _____ DOB: _____

Insured's Gender: Male _____ Female _____

Insured's Employer or School: _____

PRIMARY INSURANCE COMPANY: _____

Address (where to mail claims): _____

City: _____ State _____ Zip _____

Policy Number : _____ Group Number: _____

SECONDARY INSURANCE COMPANY: _____

Insured's Name: _____

Insured's Address: _____

City: _____ State _____ Zip _____

Insured's Social Security Number: _____ DOB: _____

Insured's Gender: Male _____ Female _____

Insured's Employer or School: _____

Insurance Company Address: _____

Policy Number: _____ Group Number: _____

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CONFIDENTIALITY

The confidentiality of the material discussed in therapy will be upheld at all times. As a general rule, Carolina Psychological Associates, P.A. will not release any information without your written consent. We are a group practice. We can consult with our associates when clinically advisable. Each clinician in the group shares emergency coverage, and the clinician who is on-call will have access to information relevant to responding to emergencies.

THERE ARE SOME EXCEPTIONS TO THE CONFIDENTIALITY RULE:

When a child is in treatment and the parents are divorced, and the parents have joint custody, the N.C. Attorney General's Office has advised us that as psychotherapists, we are obligated to inform both parents that the child is in treatment and the nature and course of treatment.

If a therapist suspects that child abuse or neglect has occurred, the law requires that it be reported to the proper authorities. Child abuse includes sexual exploitation and physical or mental injuries that result in impaired functioning. Child neglect includes failure to provide for the basic needs of the child (including medical care) and inappropriate discipline.

If a therapist believes you to be a clear and imminent danger to yourself or another person, she or he must take steps to prevent that occurrence. These steps may require breaking confidentiality.

In a legal proceeding, client-therapist communications are privileged. A judge can, however, order the therapist to divulge confidential information if this information is deemed necessary for the proper administration of justice. There is one exclusion; N.C. law provides that a marriage counselor is incompetent to testify in any subsequent legal action regarding divorce.

Your records can be released without your consent to prove to the appropriate agencies, that Carolina Psychological Associates, P.A. is in compliance with federally mandated HIPAA privacy laws.

Your records can be released without your consent upon request from the military for purposes of national security.

Filing insurance always requires giving the insurance company, or third party payor, a diagnosis and the date of service. If you are covered through an employee group health plan, this information may come back to an insurance administrator at the place of employment. Sometimes insurance companies or third party payors require more extensive information before processing claims. This does not usually come back to the employer. If you are concerned about this, you should check to see how your company protects insurance information.

If the use of a collection agency or attorney is necessary to collect a past due balance, your right to confidentiality is curtailed. While no clinical information would be revealed, your name, your employer, etc. and the amount owed, becomes available to these agents.

If you have any concerns regarding confidentiality, please feel free to discuss them with your therapist.

Signing below indicates that I have read and understand the limits to my confidentiality.

Client (or parent/guardian) Signature

Date

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EMERGENCY PROCEDURES

Carolina Psychological Associates, P.A. provides emergency services, 24 hours a day, 7 days a week, to clients actively in therapy. All clinicians in the group take turns providing emergency call services. You cannot be sure that you will be able to talk to your primary therapist. You can be sure that you will talk to a qualified, experienced, caring mental health professional.

To reach the on-call therapist in an emergency situation, call our regular telephone number, **(336) 272-0855**. If the front office is closed, you will get our recorded message. That message will direct you to call our pager number, **(336) 230-5079**. This number will page the on-call therapist.

This system works with accuracy and promptness. If your call has not been returned within 30 minutes, page us again.

If for some reason, if this system does not work, you may access emergency services in the community from the following sources:

Your psychiatrist, if you have one.

Guilford County Mental Health Emergency Services 1800-711-2635 or
(336) 832-9700

Your local Mental Health Center, if you live outside of Guilford County

Moses Cone Behavioral Health Systems 1800-711-2635 or
(336) 832-9700
700 Walter Reed Drive, Greensboro, N.C.

ADULTS CAN GO TO:
Wesley Long Hospital (336) 832-1000
501 N. Elam Avenue, Greensboro, N.C.
(Go to the Emergency Room Entrance)

CHILDREN AND ADOLESCENTS GO TO:
Moses H. Cone Memorial Hospital (336) 832-9000
1200 North Elm Street, Greensboro, N.C.
(Go to the Emergency Room Entrance)

In the event of an immediate life-threatening emergency, call 911, and the police or an emergency response team will be called if the emergency room cannot be reached in time.

Sometimes primary care physicians can help you assess a psychiatric emergency and make recommendations for care.

If you receive emergency services from providers outside of this group, always contact your primary therapist as soon as possible after the emergency.

I have read this statement and understand the procedures to be followed in case of an emergency.

Client (or parent/guardian) Signature

Date

Carolina Psychological Associates, P.A.
5509-B West Friendly Avenue
Suite 106
Greensboro, NC 27410

REFERRAL SOURCE

Please mark each source that referred you to Carolina Psychological Associates.

CHECK MARK ONLY, DO NOT LIST NAMES

Friend _____

Physician _____

Psychotherapist _____

Psychiatrist _____

Phone Book _____

Clergy _____

Attorney _____

Employee Assistance Program _____

Insurance Carrier _____

One of our Clients (current or former) _____

Co-worker _____

Teacher _____

Guidance Counselor _____

Website _____

Other _____

Once you obtained the name of the counselor, how did you find our phone number and/or contact information ?

Internet _____

Phone book- White pages _____

Phone book- Yellow pages _____

Information provided by the person/office that told you about us _____

Other _____

(Specify)

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NORTH CAROLINA NOTICE FORM

Notice of Psychologists/Psychotherapists' Policies and Practices 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

I 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 I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I 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 I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I 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

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

- **Child Abuse:** If you give me information which leads me to suspect child abuse, neglect, or death due to maltreatment, I 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, I must do so.
- **Adult and Domestic Abuse:** If information you give me gives me reasonable cause to believe that a disabled adult is in need of protective services, I 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 I 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 I have provided you and/or the records thereof, such information is privileged under state law, and I 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:** I 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, I am 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 Psychologist'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, I am 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, I 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 my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I 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. I may deny your request. On your request, I 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, I 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 me upon request, even if you have agreed to receive the notice electronically

Psychotherapists' Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify any active clients 30 days prior to the change of policy by posting in the office and written notification if one is an active client.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Dr. Michie Dew and/or Lisa Pearson, Privacy Officers at (336) 272-0855. 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 into effect on April 1, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by posted notice in the office, written notification if you are an active client at the time of the change of terms 30 days prior to the change.

Your signature below indicates that you have read this agreement and understand and agree to its terms. It also serves as acknowledgement that you have read and understand and agree with our Psychologist-Patient Services Agreement.

Client or Parent/Guardian Signature

Date