

INSTRUCTIONS TO CLIENTS PRIOR TO FIRST SESSION

Clients need to call their insurance carrier and ask the following five questions prior to your first session.

1. Do you need pre-certification? 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 are authorized for, and get expiration date if applicable. Get the name and location of the individual you talked to.
2. Is there a deductible? How much is it and has any been met? Again, get the name of the person you talked to and their location.
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 not 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 or behavioral health specialists this year? If so, how many sessions do you have left?
5. Does your employer provide an Employee Assistance Program (EAP)? If you have an EAP benefit, you will need to obtain information about which EAP you are using. You will need the same information as above. Number of sessions, authorization number, beginning date and expiration date, if any. There are 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 and money orders. **NO PLASTIC.** We will provide a receipt, if needed, for to you use for reimbursement from your flex plan, or health savings account.
- * If any amount is paid by 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 pre-certification, and provide your therapist with the pre-authorization number.
- * 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 the employers name.

CAROLINA PSYCHOLOGICAL ASSOCIATES, P.A.

5509-B West Friendly Avenue, Suite 106

Greensboro, NC 27410

Telephone: (336) 272-0855

Fax: (336) 272-9885

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:

Name: _____

Address: _____

PER NORTH CAROLINA STATE LAW: The financially responsible person is the adult who signs the consent for services.

THE FINANCIALLY RESPONSIBLE ADULT IS THE PERSON WHO SIGNS THE CONSENT FOR SERVICES.

Name of person referring you to me: _____

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

Please list the names, ages, and relationship to this child of those (other than parents) living in the home:

Name	Age	Relationship (brother, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list other family members no longer living at home:

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

Describe any unusual health problems of child: _____

Is the child taking any prescribed medication? Yes _____ No

If yes, explain: _____

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

Briefly describe your child's main problems. (Describe the problems, when they began, when they happen now, what you do to handle them, etc.): _____

(Please use back of page if additional space is needed)

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:_____ If child has been seen by any of these specialists in school, please check: School Psychologist_____ Speech Therapist_____ Learning Disability Teacher

Is your child in any special classes at school? Yes_____ No_____ If so, what class(es) and how often?

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
- _____ Uses 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 obvious reason
- _____ Problems with appetite: eats too little_____ or too much_____
- _____ Has difficulty sleeping
- _____ Wets or soils self

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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 for 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 or cash.

INSURANCE: As a courtesy, we file your insurance for you. However, the client is expected to pay for non-allowable and deductible charges, as well as co-payments, when services are rendered. If insurance payment is not received with **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 company for delayed payments or other concerns.**

BILLING: We will bill clients monthly after insurance has been filed. This is a reminder of 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 balances and co-payments due.

REFUNDS ARE ISSUED ONCE A MONTH, ONLY AFTER ALL PENDING 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 AND 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 fees. **It is the client's responsibility to know the amount of their deductible and/or 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 carrier's time limit" that is the result of failure by the client to inform this office of changes in insurance coverage.

We appreciate the opportunity you have provided for us to be of service to you. If you have any questions, please discuss them with us. I have read, understand, and agree with the Fee Information guidelines outlined above.

Client (or parent) Signature
Fee.Form update 7/2003

Date

CAROLINA PSYCHOLOGICAL ASSOCIATES, P.A.

www.CarolinaPsychological.com

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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 parent have joint custody, the N. C. Attorney General's Office has advised us that as therapists, 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 proper authorities. Child abuse includes sexual exploitation and physical or mental injuries that result in impaired functioning. Child neglect included 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 the department of Social Services, or for the purpose of completing Workers Compensation claims.

Your records can be released without your consent to prove to the appropriate agencies, that Carolina Psychological is in compliance with federally mandated HIPPA privacy rules.

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 dates 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 payers 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 account, your right to confidentiality is curtailed. While no clinical information would be revealed, your name and the amount you owed becomes available to these agents.

If you have any concerns regarding confidentiality, please feel free to discuss them with your therapist. I understand these limits to my confidentiality.

Client (or Guardian) Signature

Date

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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

INSURANCE INFORMATION

DID YOU CALL FOR PREAUTHORIZATION? NO _____ YES _____

PREAUTHORIZATION NUMBER: _____

MANY INSURANCE COMPANIES REQUIRE PREAUTHORIZATION FOR MENTAL 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 REDUCTION OF 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 copayment 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. Also, copayments of what insurance is know not to pay must be made at appointment time.**

Client's Name: _____

Client's relationship to insured: _____

Client's status: Single _____ Employed _____
Married _____ Full time student _____
Other _____ Part time student _____

Insured's Name: _____

Insured's Address: _____

City _____ **State** _____ **Zip** _____

Insured's ID# (Social Security Number) _____

Insured's Sex: Male: _____ Female: _____

Insured's Date of Birth: _____

Insured's Employer Name or School Name: _____

PRIMARY INSURANCE COMPANY: _____

Address (where to mail claim form): _____

City _____ **State** _____ **Zip** _____

Policy or Group Name or Number: _____

SECONDARY INSURANCE COMPANY: _____

Insured's Name: _____

Insured's Address: _____

City _____ **State** _____ **Zip** _____

Insured's ID# (Social Security Number) _____

Insured's Sex: Male: _____ Female: _____

Insured's Date of Birth: _____

Insured's Employer Name or School Name: _____

Insurance Company Address: _____

City _____ **State** _____ **Zip** _____

Policy or Group Name or Number _____

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REFERRAL SOURCE*

*(Please mark each source that referred you to **Carolina** Psychological Associates)*

Type _____

Name _____

Physician _____

Friend _____

(do not record a name)

Psychotherapist _____

Yellow Pages _____

Clergy _____

Attorney _____

EAP _____

Insurance _____

Client (former or current) _____

(do not record a name)

Co-Worker _____

School Guidance _____

Counselor _____

Teacher _____

Other _____

Website _____

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NORTH CAROLINA NOTICE FORM

Notice of Psychologists' 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. 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 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 our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

“*Disclosure*” applies to activities outside of our practice, 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 that have made about our conversation during a private, group, joint, or family counseling session, which we have 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 your therapist information which 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 Psychologist's Duties

Patient's Rights:

- C *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.

- C *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 at our practice. Upon your request, we will send your bills to another address.)
- C *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. 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.
- C *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, I will discuss with you the details of the amendment process.
- C *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.
- C *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

Psychotherapist's Duties:

- C 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.
- C 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.
- C If I revise my policies and procedures, I will post the changes in the waiting room and place a brief notice of changes in the statement of professional services that is mailed out monthly, and on our website. Notice will be posted 30 days prior to the change(s).

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, you may contact Dr. Michie Dew, President of Carolina Psychological Associates at 336 272-0855 or Lisa Pearson, office manager at this same number

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The office manager can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

and Changes to Privacy Policy

This notice will go into effect on April 1, 2003.

Carolina Psychological Associates, P.A. reserves 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 a revised notice by posting it in our office, written notification included with our monthly Statement of Professional Services, which you will receive if you are an active client and on our website. The notice will be posted 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 acknowledgment that you have read and understand and agree with our Psychologist-Patient Services Agreement.

Client or Parent/Guardian Signature

Date