

**CAROLINA PSYCHOLOGICAL ASSOCIATES, P.A.**  
**5509-B West Friendly Avenue, Suite 106**  
**Greensboro, NC 27410**  
**Telephone: (336) 272-0855**  
**Fax: (336) 272-9885**

**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