CAROLINA PSYCHOLOGICAL ASSOCIATES

5509-B W. Friendly Avenue, Suite 106, Greensboro, NC 27410 • 1777 Fordham Blvd., Suite 202-1, Chapel Hill, NC 27514

New Client Information (Under 18-years old)

Today's Date: _____

CLIENT IDENTIFYING INFORMATION

Client's Full Name: _____ Preferred Name: _____
Date of Birth: _____ Age: _____ Gender: M___ F___ Other (Describe) _____
Address: _____ City/State/Zip: _____
Home Phone: _____ ☐ Voice messages OK (check box if 'yes')
Cell Phone: _____ ☐ Voice messages OK (check box if 'yes')
Email: _____ ☐ I understand that email may not be secure to third-party intrusion
Preferred Pronoun(s): _____

Adopted: ☐ Yes ☐ No

School: _____ Current Grade: ___ Teacher: _____
Employment: ☐ None ☐ Part-time ☐ Full-time Occupation: _____

Parent/Guardian's Name: _____
Address: _____ City/State/Zip: _____
Date of Birth: _____ SSN (REQUIRED): _____
Place of Employment & Occupation: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ ☐ I understand that email may not be secure to third-party intrusion
Please indicate where you prefer to be contacted: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email
Please indicate where we have permission to leave a message: ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email

Co-Parent/Guardian's Name: _____
Address: _____ City/State/Zip: _____
Date of Birth: _____ SSN (REQUIRED): _____
Place of Employment & Occupation: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ ☐ I understand that email may not be secure to third-party intrusion
Please indicate where you prefer to be contacted: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email
Please indicate where we have permission to leave a message: ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email

Person responsible for payment: _____
Relationship to minor: _____
The financially responsible adult is the person who signs the Consent for Services Agreement

I would like to receive email reminders of my appointments: ☐ Yes ☐ No
Email address for appointment reminders: _____

Referred to CPA by: ☐ Insurance Provider ☐ Internet/Website ☐ Psychology Today
☐ Doctor's Office (List Doctor & Office): _____
☐ Personal Referral: _____ ☐ Other: _____
May we send them a thank you note? ☐ Yes ☐ No
Address to send the note: _____
Or Email to send the note: _____

Please list information about your child's immediate family members and others living in your home:

Relationship (mother, father, sister, brother)	Name	Age	Deceased (Y/N)	Current City, State	Relationship (excellent, good, fair, poor)	Physical or Mental Illness	Living in Home (Y/N)

Are there any other people living in the family home(s): _____
Has the family experienced any significant stressors in the past 12 months (Describe): _____
_____

Are client's parents married: ☐ Yes ☐ No
If no, please indicate parents' relationship status: ☐ Partnered ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed
If not, parent remarried? ☐ Yes ☐ No
Stepparent's Name: _____
Co-Parent remarried? ☐ Yes ☐ No
Stepparent's Name: _____
What are the client's current living arrangements? _____
If divorced or separated, who has legal custody? _____
If custody, sole custody or joint custody? _____
**In compliance with NC law, when there is joint custody, we are obligated to inform the other parent that your child is going to be receiving services.*

Are you currently, or do you expect to become, involved in any legal proceedings: ☐ Yes ☐ No
If so, please describe: _____

_____

Client's Physician and Place of Practice: _____
Previous Diagnoses: _____
Current Medications and Name of Prescriber: _____

Does your child have problems with: Vision? ☐ Yes ☐ No Hearing? ☐ Yes ☐ No
If yes, please explain: _____

Has your child received mental and/or behavioral health services from another provider? ☐ Yes ☐ No
If yes, please provide the following information:

Provider	When	Type of Service

When did their symptoms begin? _____

_____

Does your child receive: Speech-Language Therapy ___ Occupational Therapy: ___ Physical Therapy: _____
Special Education Services: ____ Other Therapies: _____
If yes, please provide the following information:

Provider	When	Type of Service

Has your child been held back a grade? ☐ Yes ☐ No
Number of schools your child has attended: _____

May CPA contact the physician to coordinate care if necessary? ☐ Yes ☐ No ☐ N/A
If yes, please complete CPA's Request/Authorization to Release Confidential Records and Information Form

May CPA contact your psychiatrist, mental health counselor if applicable? ☐ Yes ☐ No ☐ N/A
If yes, please complete CPA's Request/Authorization to Release Confidential Records and Information Form

May CPA contact your spouse/partner/parent(s) to coordinate services if necessary? ☐ Yes ☐ No ☐ N/A
If yes, please complete CPA's Request/Authorization to Release Confidential Records and Information Form

Please 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
_____ Abuses prescription medications
_____ Uses alcohol, cigarettes, e-cigarettes, vapes without parental permission

MOOD AND SELF IMAGE

_____ Is anxious and worries a lot
_____ Has unusual fears (Describe): _____
_____ 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 (Describe): _____
_____ 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

Do these problems occur at home? ☐ Yes ☐ No
Do these problems occur at school? ☐ Yes ☐ No
Do these problems occur in the community? ☐ Yes ☐ No

Are there other concerns? _____

_____

_____

CAROLINA PSYCHOLOGICAL ASSOCIATES

5509-B W. Friendly Avenue, Suite 106, Greensboro, NC 27410 • 1777 Fordham Blvd., Suite 202-1, Chapel Hill, NC 27514

INSURANCE INFORMATION

Did you call for Pre-Authorization? ☐ Yes ☐ No Pre-Authorization 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 parent/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**.

Child's Name: _____
Child's relationship to the Insured Person: _____
Child's status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
☐ Unemployed ☐ Part-time ☐ Full-time ☐ Student ☐ Disability ☐ Retired

PRIMARY INSURANCE COMPANY: _____
Insured Person's Name: _____
Insured Person's Address: _____
City: _____ State: _____ Zip: _____
Insured Person's Social Security Number: _____ DOB: _____
Insured Person's Gender: M_____ F___ Other (Describe) _____
Insured Person's Employer or School: _____

Where to mail claims: Address: _____
City: _____ State: _____ Zip: _____
Policy Number: _____ Group Number: _____

SECONDARY INSURANCE COMPANY: _____
Insured Person's Name: _____
Insured Person's Address: _____
City: _____ State: _____ Zip: _____
Insured Person's Social Security Number: _____ DOB: _____
Insured Person's Gender: M_____ F___ Other (Describe) _____
Insured Person's Employer or School: _____

Where to mail claims: Address: _____
City: _____ State: _____ Zip: _____
Policy Number: _____ Group Number: _____

CLIENT-CLINICIAN AGREEMENT

CONSENT FOR SERVICES FOR A MINOR

I give my consent for psychological services to be provided to my child, _____, by CAROLINA PSYCHOLOGICAL ASSOCIATES, P.A. I understand that the sessions with Carolina Psychological Associates have been either authorized through my EAP or approved through a Managed Care Insurance program. This may mean that my child 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, 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, cell phone 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 billing and payment for such services. I understand that modern communication modalities, such as cell phone, email, and fax, are subject to difficulties. I understand that Carolina Psychological Associates, P.A. will exercise all reasonable precautions, and I in no way will 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 email, fax or cell phone. 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. North Carolina State law allows mental health and medical providers to share client information with other mental health providers, without obtaining the client's written consent, when necessary to coordinate care and treatment. This applies between mental health providers and other health care providers and is regulated by Federal HIPAA Laws (1999). This allows a referring psychotherapist or physician to be informed about a client they have referred.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation: When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although the therapist's responsibility to your child may require them helping to address conflicts between the child's parents, their role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena the records or ask the therapist or Carolina Psychological Associates, P.A. to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing their opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring their testimony, even though they will not do so unless legally compelled. If they are required to testify, they are ethically bound not to give their opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, they will provide information as needed, if appropriate releases are signed or a court order is provided but will not make any recommendation about the final decision(s). Furthermore, if required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for their participation agrees to reimburse them at the rate of $250.00 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs. These fees are not covered by insurance. Carolina Psychological Associates, P.A. is not a forensic practice and does not choose to be involved in litigation, and we are opposed to it as we do not believe it to be therapeutic.

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

CONFIDENTIALITY

The confidentiality of the material discussed in therapy with 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. If you have any concerns regarding confidentiality, please feel free to discuss them with your therapist.

In the course of treatment of your child, the therapist may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, the patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If the therapist meets with you or other family members in the course of your child's treatment, they will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Disclosure of Minor's Treatment Information to Parents: Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is our policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to the therapist without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then the therapist will need to use their professional judgment to decide whether your child is in serious and immediate danger of harm. If they feel that your child is in such danger, they will communicate this information to you.

Even when we have agreed to keep your child's treatment information confidential from you, the therapist may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, the therapist will encourage your child to tell you, and will help your child find the best way to do so. Also, when meeting with you, the therapist may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents: Although the laws of North Carolina may give parents the right to see any written records the therapist keeps about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with the therapist, and you agree not to request access to your child's written treatment records.

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.
- Per North Carolina Law (eff. 1/1/2012), mental health and medical providers may share client information with other mental health and medical providers, without obtaining the client's written consent, when necessary to coordinate care and treatment. This applies between mental health providers and other health care providers (such as psychiatrists, primary care physicians and pediatricians) regulated by the 1999 Health Insurance Portability and Accountability Act. This allows a referring psychologist or physician to be informed about a client they have referred. We will follow this law's provisions unless you let us know otherwise.
- 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 the agents.

ELECTRONIC COMMUNICATION AND SOCIAL MEDIA POLICIES

ELECTRONIC COMMUNICATION:

The transmission of client information by email has a number of risks that clients should consider prior to the use of email. These include, but are not limited to, the following risks:

- Email can be circulated, forwarded, stored electronically, and sent to unintended recipients.
- Email senders can easily misaddress an email and send the information to an undesired recipient.
- If sharing an email address with someone else, that person will be able to review your communications.
- Backup copies of emails may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers have a right to inspect emails sent through their company systems.
- Unencrypted emails can be intercepted, altered, forwarded or used without authorization or detection, especially when using a smart phone or tablet.
- Email can be used as evidence in court.
- Emails may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party (e.g., hackers, commonly used email advertising scans, etc.).

Conditions for the use of email and texts: CPA and its therapists cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. CPA and its therapists are not liable for improper disclosure of confidential information that is not caused by their intentional misconduct.

Clients/Parents/Guardians must acknowledge and consent to the following conditions:

- Clients/parents/guardians in our practice may be contacted via email for appointment reminders, evaluation purposes (links to secured online portals for completion of psychological tests), account issues, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
- Therapists will not engage in "therapy," offer advice, or respond to clinical issues through email. You will be informed that the issues must be addressed via phone consultation (may be subject to fee not covered by insurance) or at your next scheduled appointment.
- Email is not appropriate for urgent or emergency situations. CPA and its therapists cannot guarantee that any particular email will be read and responded to within any particular period of time.
- If you have not heard back from your therapist in three (3) business days, please check your spam folder. If a response is not there, please contact the office.
- The client/parent/guardian will not include personal identifying information in any emails sent to CPA and its therapists. If a client/parent/guardian does communicate confidential or private information via email, we will assume you have made an informed decision to do so.
- Email should be concise. The client/parent/guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- All email will usually be printed and filed into the client's medical record.
- CPA and its therapists will not forward client's/parent's/guardian's identifiable emails without the client's/parent's/guardian's written consent, except as authorized by law.
- Clients/parents/guardians should not use email for communication of sensitive medical information.
- CPA and its therapists are not liable for breaches of confidentiality caused by the client or any third party.
- It is the client's/parent's/guardian's responsibility to follow up and/or schedule an appointment if warranted.
- If clients/parents/guardians would like to use a more secure form of communication, please use our secured fax line or communicate over the phone by calling our office phone number.
- If you need to send any attachments, please either fax them to us or send them as a secured file that is password protected.

SOCIAL MEDIA

CPA has an online presence on certain social media sites (i.e., Facebook, LinkedIn) so that clients and potential clients can learn more about the services that we provide. CPA and its employees will not "friend" and/or communicate with current or previous clients through social media. This policy exists in order to ensure and protect the privacy of our clients and so that the therapeutic relationship is not affected by boundary confusion. Moreover, CPA does not use social media to obtain information about our clients, except when we are concerned about the safety of a client or others (i.e., risk of harm to self or others).

TEXT MESSAGING

Because text messaging is a very unsecure and impersonal mode of communication, we do not text message to nor do we respond to text messages from anyone in treatment with our therapists. So, please do not text message unless we have made other arrangements.

WEBSITE

We have a website that you are free to access. We use it for professional reasons to provide information to others about our practice. You are welcome to access and review the information that we have on our website and, if you have questions about it, it should be discussed during your therapy sessions.

WEB SEARCHES

We will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, we understand that you might choose to gather information about your therapist in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about your therapist or this practice through web searches, or in any other fashion for that matter, please discuss this with your therapist during your time together so that we can deal with it and its potential impact on your treatment.

Recently it has become common practice for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of the practice and its therapists, or any professional with whom you are working, please share it with your therapist so you can discuss it and its potential impact on your therapy. Please do not rate your experience while you are in treatment on any of these websites. This is because it has a significant potential to damage our ability to work together.

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 **$175.00** for an initial intake, **$140.00** for a 45-minute session of psychotherapy, **$150.00** for a 60-minute session, and **$150.00** 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 and HSA cards. Carolina Psychological Associates is not a forensic practice and does not choose to be involved in litigation, and we are opposed to it as we do not believe it to be therapeutic. If circumstances require so, our fees for involvement in any legal process are **$250.00** per hour including preparation for court, travel, wait times, meetings, and telephone calls for the case as well as court time. These fees are not covered by insurance. The therapeutic relationship is legally considered privileged. Therefore, the therapist's involvement in litigation has to be authorized in writing by the client or if a court orders the therapist's involvement. Requests for a review and copies of records are subject to a $25.00 fee, not reimbursable by insurance.

INSURANCE: As a courtesy, we will file your insurance for you. However, the client is expected to pay for noncovered 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 his or her 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 carrier's time limit", that are the result of failure by the client to inform this office of changes in insurance coverage. **The client also acknowledges that psychological testing may not be covered, or not covered fully, by their insurance carrier. If you or your child are here for psychological testing, please be aware that pre-authorization does not guarantee payment or payment in full by your insurance carrier, or other third-party payor.**

EMERGENCY PROCEDURES

Effective November 1, 2019, Carolina Psychological Associates will no longer be offering 24/7 emergency services to our clients actively involved in therapy, and our emergency number **WILL NO LONGER BE IN SERVICE**. Our clinicians will continue to provide psychotherapeutic services during normal business hours. You may leave your therapist a message and they will return your call as soon as possible, usually within 24 business hours. Carolina Psychological Associates cannot guarantee that your therapist will be personally available to handle emergencies. For after-hours emergencies or if you need immediate assistance, please call 911 or visit your local emergency room, medical group, or primary physician.

Other resources that are available to you 24/7 include:

- Emergency Medical Services: 911
- Therapeutic Alternatives, Mobile Crisis 1-877-626-1772
  (Or your local mental health center, if you live outside of Guilford County)
- Moses Cone Behavioral Health Systems 336-832-9700 or 1-800-711-2635
  700 Walter Reed Drive, Greensboro, NC
- Moses H. Cone Memorial Hospital 336-832-9000
  1200 North Elm Street, Greensboro, NC
- Wesley Long Hospital 336-832-1000
  501 N. Elam Avenue, Greensboro, NC
- Old Vineyard Behavioral Health 1-888-477-1287
  3637 Old Vineyard Road, Winston-Salem, NC
- National Suicide Prevention Hotline 1-800-273-TALK (8255) and https://suicidepreventionlifeline.org/chat/
- Crisis Text Line https://www.crisistextline.org/

As before, if you receive emergency services from providers outside of this group, always contact your primary therapist as soon as possible after the emergency. If you have any questions about this change in policy, please contact us or discuss this with your therapist at your next scheduled appointment.

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* 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 a 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.

- Must sign and authorization for:
  a) Most uses and disclosures of psychotherapy notes (if you keep separate psychotherapy notes)
  b) Uses and disclosures of PHI for marketing purposes (e.g. sending communications to your list of clients about new services you are offering); and
  c) Disclosures that constitute a sale of PHI

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) 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.

- **Workers 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 Psychotherapist's Duties

- Patient's Rights: Per North Carolina Law, (effective 01/01/2012), mental health and medical providers may share client information with other mental health providers, without obtaining the client's written consent, when necessary to coordinate care and treatment. This applies between mental health providers and other health care providers (such as psychiatrists, primary care physicians and pediatricians) regulated by the 1996 Health Insurance Portability and Accountability Act. This allows a referring psychologist or physician to be informed about a client they have referred. We will follow this law's provisions unless you let us know otherwise.
    - *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 Communication 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 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 II 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 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.
  - I have the right to restrict certain disclosures of Protected Health Information (PHI) to a health plan if they pay out-of-pocket in full for the healthcare service. (This new right is discussed in Section E.1. of the HIPPA Final Rule document.)
  - I have the right to be notified if there is a breach of their unsecured PHI.

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 Heather McCain, Psy.D. and/or Sarah Gates, LPA, 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 14, 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.

PATIENT'S RIGHTS & RESPONSIBILITIES

- Patients have the right to be treated with personal dignity and respect.
- Patients have the right to care that is considerate and respects member's personal values and belief system.
- Patients have the right to personal privacy and confidentiality of information.
- Patients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and patient rights and responsibilities.
- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Patients have the right to participate in an informed way in the decision-making process regarding their treatment planning.
- Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.
- Patients have the right to individualized treatment, including:
    1. adequate and humane services regardless of the source (s) of financial support,
    2. provision of services within the least restrictive environment possible,
    3. an individualized treatment or program plan,
    4. periodic review of the treatment or program plan,
    5. an adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.
- Patients have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including:
    1. Resolving conflict,
    2. Withholding resuscitative services,
    3. Forgoing or withdrawing life-sustaining treatment, and
    4. Participating in investigational studies or clinical trials.
- Patients have the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Patients and their families have the right to be informed of their rights in a language they understand.
- Patients have the right to voice complaints or appeals about managed care company or the care provider.
- Patients have the right to make recommendations regarding managed care company rights and responsibilities policies.
- Patients have the right to be informed of rules and regulations concerning patients' conduct.
- Patients have the responsibility to give their provider and managed care company information needed in order to receive care.
- Patients have the responsibility to follow their agreed upon treatment plan and instructions for care.
- Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with their provider mutually agreed upon treatment goals.

ATTESTATION AND ACKNOWLEDGEMENT

If you have any questions about the above information, please discuss them with the office manager and/or your therapist. Your signature below indicates that you attest to the information that you provided in these forms and that you have read, understood, and agree to the **Client-Clinician Agreement** which includes:

- Consent for Treatment
- Confidentiality Agreement
- Electronic Communication and Social Media Policy
- Fee Information
- Emergency Procedures

It also serves as acknowledgement that you have reviewed the HIPAA information that contains the NC Notice Form, the Psychologist-Patient Services Agreement, and the Patient's Rights and Responsibilities. You may request a copy of these notices for your records.

Parent/Guardian Signature _____ Date _____

PRINT Your Name Here _____

Clinician Signature _____ Date _____

If the client is a minor and there is joint custody between two parents, we also request the consent and signature of the other parent:

Parent/Guardian Signature _____ Date _____

PRINT Your Name Here _____