CAROLINA PSYCHOLOGICAL ASSOCIATES

1501 Highwoods Blvd., Suite 101, Greensboro, NC 27410 • 1777 Fordham Blvd., Suite 202-1, Chapel Hill, NC 27514

Client Information (18-years and older)

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
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
I would like to receive email reminders of my appointments: ☐ Yes ☐ No
I would like to have my email added to receive the newsletter: ☐ Yes ☐ No

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

SSN (REQUIRED): _____

Employment: ☐ None ☐ Part-time ☐ Full-time ☐ Student ☐ Disability ☐ Retired
Employer: _____ Occupation: _____

Spouse/Partner 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
Please indicate where they 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

SSN (REQUIRED): _____

Employment: ☐ None ☐ Part-time ☐ Full-time ☐ Student ☐ Disability ☐ Retired
Employer: _____ Occupation: _____

Emergency Contact Person: _____
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
Relation to you: _____

INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD (FRONT AND BACK)

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 ARE NOT IN NETWORK WITH NC MEDICAID. IF YOU HAVE COMMERCIAL INSURANCE, WE WILL GLADLY FILE WITH YOUR PRIMARY INSURANCE, WITH YOU HAVING THE UNDERSTANDING THAT THE COPAY AND/OR DEDUCTIBLE IS THE RESPONSIBILITY OF THE CLIENT.

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**.

Client's Name: _____

Client's relationship to the Insured Person: _____

Client'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

PLEASE READ AND SIGN:

I give my consent for psychological services to be provided to me, _____, 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, 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.

I understand that if I involve Carolina Psychological Associates, P.A. in a legal proceeding, the fee is $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. 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.

ATTESTATION AND ACKNOWLEDGEMENT

If you have any questions, 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 continue to agree to the **Client-Clinician Agreement** which includes:

- Consent for Treatment
- Confidentiality Agreement
- Electronic Communication and Social Media Policy
- Fee Information
- Emergency Procedures
- Teletherapy Consent
- Informed Consent for In-Person Services During Covid-19 Public Health Crisis

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.

_____ _____

Client Signature Date

_____

PRINT Your Name Here

_____ _____

Clinician Signature Date