Client Information Form

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone or Pager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred way to contact you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are there any restrictions we should know about calling you? (For example: please do not call at work, please do not leave messages):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If the client is a minor or an adult with a legal guardian, please provide the following information about the parent or legal guardian:

Parent/Guardian’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone or Pager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Information Form

**Insurance Information**: If you intend to use insurance to help pay for services, please provide as much information as you know.

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification/agreement/policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group or Enrollment # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible: \_\_\_\_\_\_\_\_\_\_ per policy year. On what date does the policy year start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much of this deductible has been used so far? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount of Copay? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan pays \_\_\_\_\_\_\_\_\_\_% of Charges Usual, customary, and reasonable (UCR)

Limitations: Number of visits: \_\_\_\_\_\_\_\_\_\_ Prior authorization needed? Yes No

Additional information about benefits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**is there another insurance policy?** If so, please provide as much information about the other insurance policy as you can.

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification/agreement/policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group or Enrollment # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible: \_\_\_\_\_\_\_\_\_\_ per policy year. On what date does the policy year start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much of this deductible has been used so far? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount of Copay? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan pays \_\_\_\_\_\_\_\_\_\_% of Charges Usual, customary, and reasonable (UCR)

Limitations: Number of visits: \_\_\_\_\_\_\_\_\_\_ Prior authorization needed? Yes No

Additional information about benefits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client Information Form

I authorize the release of any medical or other information necessary to process claims submitted to the named insurer. I authorize payment of health insurance benefits to Behavioral Health Solutions for services furnished to me or to the client named above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Legal Guardian Signature of Parent/Legal Guardian Date

For Office Use:

NC Medicaid LME/PCP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NC Medicaid Authorization Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Coordination of Care Record

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of admission to services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a primary care provider? Yes \_\_\_\_\_ No \_\_\_\_\_ Is there another therapist? Yes \_\_\_\_\_ No \_\_\_\_\_

Is there an attorney or case worker? Yes \_\_\_\_\_ No \_\_\_\_\_ Is there a probation officer? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of primary care provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care provider’s phone, fax #, & email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone, fax #, & email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of attorney or case worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone, fax #, & email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of probation officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone, fax #, & email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any medications you are taking

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Prescription Date | Prescription Name | Dosage | # Times Day?  | Duration  | Prescription End Date | Ordered by |
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Information for Clients and Consent for Treatment

Welcome to Behavioral Health Solutions. We are a team of psychologists and social workers who are dedicated to providing professional mental health services to our clients. We look forward to working with you. This document describes some of the policies of our practice. Please let us know if you have any questions or concerns about any of the information in this document.

**About Our Appointments**

We take our appointments with you very seriously. We ask that you make every effort to keep you appointments with us. If you are unable to keep an appointment, please contact us to let us know. **You will be charged the full session fee for sessions cancelled with less than 24 hours’ notice, for other than the most serious reasons.** Your insurance will not cover the charge for missed appointments. If a client has 3 or more “no shows” or late cancellations, we have the option to suspend or terminate treatment.

Please, do not bring pets with you to the office. While we love to see your fur babies, not everyone that visits our office feels the same way.

Clients are expected to use the front door between the hours of 9:00 AM and 6:00 PM.

Clients and anyone with them (such as friends or family members) must be sober when in our office. Clients who appear to be under the influence of drugs or alcohol when they arrive for an appointment will be asked to leave and considered a “no show.” Friends, family members, or other people who appear to be under the influence of drugs or alcohol will also be asked to leave.

If you need to contact us between sessions, please leave a message with our office manager or on our voice mail (919-419-0524, extension 0).

If we are unable to keep a scheduled appointment, we will contact you as soon as possible to let you know. It is your responsibility to keep your contact information current.

**Children**

Children under the age of 16 must be supervised by a responsible adult at all times. We do not provide supervision.

**Medical Emergencies while at our office**

If you experience a medical emergency while at our office we are obligated by law to solicit emergency treatment on your behalf.

Information for Clients and Consent for Treatment

**About Confidentiality**

Refer to the **Notice of Privacy Practices** regarding the privacy of our records, and refer to the **Patient’s Rights** document about your rights as a client regarding your medical record. At this point, however, we will review a few issues regarding confidentiality and privacy that are not covered in the **Notice of Privacy Practices.**

Because all of our clients expect confidentiality, we ask you not to disclose the name or identity of any other client being seen in this office.

It is our office policy to retain clients’ records for 12 years after the end of services. During that time, we will keep case records in a safe place. After 12 years we will destroy these records (unless the client is a minor, in which case the records will be destroyed once the minor reaches age 30.)

If we must discontinue our relationship because of illness, disability or other presently unforeseen circumstances, we ask you to agree to us transferring your records to another mental health professional who will assure their confidentiality, preservation, and appropriate access.

If we provide family or couple therapy (where there is more than one client), and you want to have the records of this therapy released to someone else, all of the adults involved in the treatment will have to sign a release.

As noted in the **Notice of Privacy Practices**, you can review your own records at any time. However, you may not examine records we have received from an outside source. You will need to contact the source of those records.

It is also worth stating again that, as part of cost control efforts, an insurance company will sometimes ask for more information on symptoms, diagnosis, and treatment methods. We will let you know if this should occur and what the company has asked for. Please understand that we have no control over how these records are handled at the insurance company. Our policy is to provide only as much information as the insurance company will need to pay your benefits.

**Fees, Payments, & Billing**

We charge $125.00 for a one-hour session (usually 50-60 minutes). Initial sessions are sometimes longer (up to 90 minutes), giving us time to gather important assessment information; those initial sessions are $175.00. Payment is due at the beginning of each session. We accept cash, personal checks and credit cards. For clients covered by insurance, copays are due at the beginning of each session. If you wish, we can give you a statement at each session that will serve as a record of payment.

In addition to the fee for each visit, fees for services not covered by insurance (such as telephone consultations and missed appointments) are due upon receipt of the statement. You are also responsible for charges denied because the services are not covered or because you did not comply with the guidelines of your insurer.

Information for Clients and Consent for Treatment

If your account has a balance you will receive a statement in the mail. If your balance remains unpaid after a reasonable period of time, we have the option of terminating treatment and/or using legal means to secure payment.

**Insurance Reimbursements**

In order for us to set realistic goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Always remember though, that you (and not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers.

**Other Points**

If you ever become involved in a divorce or custody dispute, you should understand that we will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you may require. This position is based on two reasons: (1) Our statements will be seen as biased in your favor because we have a therapeutic relationship; and (2) the testimony might affect our therapeutic relationship, and we must put the therapeutic relationship first.

Information for Clients and Consent for Treatment

**Emergency Procedures**

If an urgent situation arises and you cannot reach your psychotherapist quickly, please make use of the local

Emergency services in your community. Some important emergency services are listed below:

 UNC Hospital Emergency Room 919-966-4721

 Duke Hospital Emergency Room 919-688-7378

 HELPLINE (in Chapel Hill) 919-929-0479

 HELPLINE (In Durham) 919-683-8628

 Hopeline (in Raleigh) 919-828-4300

 Police/Sheriff/Rescue 911

Information for Clients and Consent for Treatment

**Statement of Principles and Complaint Procedures**

Problems can arise in your relationship with a mental health treatment provider, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concern with your psychotherapist at once. Your work together will be slower and harder if your concerns are not worked out. We will make every effort to hear any complaints you have and to seek solutions to them in a timely manner. Some complaints can be addressed quickly, and other complaints may take longer to resolve. When we discuss your complaint with you, we will give you an estimate of how long we may need to address your complaint.

Our practice does not discriminate against clients because of age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. We will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring the matter to our attention immediately.

If you are dissatisfied with our response to your grievance/complaint or if you do not feel comfortable filing a grievance/complaint directly with us, you have the right to file a grievance/complaint with companies and agencies outside of Behavioral Health Solutions.

For Medicaid recipients who are covered by Cardinal Innovations Healthcare Solutions (Orange, Person, Chatham, Franklin, Granville, Halifax, Vance, Warren, Alamance, Caswell, Cabarrus, Davidson, Rowan, Stanly, and Union Counties):

 Call the Cardinal Innovation Healthcare Solutions number at 1-800-939-5911

For Medicaid recipients who are covered by Alliance Behavioral Healthcare (Durham, Wake, Cumberland, and Johnston Counties):

 Call the Access and Information Line at 1-800-510-9132

For Blue Cross Blue Shield members:

 Call BCBSNC Customer Service at 1-877-258-3334

For CIGNA members:

 Call CIGNA Customer Service at 1-800-997-1654

For United Healthcare Members:

 Call United Healthcare Customer Service at 1-800-842-8000

For AETNA members:

 Call AETNA Customer Service at 1-800-872-3862

Information for Clients and Consent for Treatment

Psychologist in North Carolina are licensed by the North Carolina Psychology Board. Social workers in North Carolina are licensed by the North Carolina Social Work Certification and Licensure Board. If you believe a mental health professional at Behavioral Health Solutions has acted unethically, you have the right to file a complaint with the relevant licensing board.

To file a complaint with the North Carolina Social Work Certification & Licensure Board, submit the complaint in writing to the Board office:

NCSWCLB,

PO Box 1043

Asheboro, NC 27204,

or see www.ncswboard.org or call 1-800-550-7009 for more information.

To file a complaint with the North Carolina Psychology Board: complete a Complaint/Inquiry Form at

www.ncpsychologyboard.org

You may call the Psychology Board at 1-828-262-2258 for more information.

Clients with disabilities may also contact Disability Rights North Carolina at:

1-877-235-4210 or 919-856-2195.

The mailing address is 2626 Glenwood Avenue, Ste. 550, Raleigh, NC 27608.

The website is www.disabilityrighsnc.org.

Consent for Treatment

I have read, or have had read to me, the information in this document. I have discussed those points I did not understand, and I have had any questions answered fully. I agree to act according to the points covered in this document.

I agree to receive professional mental health services (or agree for my child or dependent to receive services) from Behavioral Health Solutions.

I understand that I have the right to refuse treatment. I also understand that I have the right to withdraw from treatment at any time. In the event that I have been referred to Behavioral Health Solutions by another professional or agency, I understand that Behavioral Health Solutions may need to notify the referring professional or agency that I have refused or withdrawn from treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name if different from client

Relationship to client

 Self Parent Legal Guardian

Patient’s Rights

* Right to Receive Treatment**:** You have the right to receive treatment, including access to medical care and habilitation, regardless of your age or your degree of mental health, intellectual and development disability, or substance abuse disability.
* Right to Least Restrictive Environment: You have the right to receive care in the least restrictive environment suitable to meet your needs.
* Right to Privacy: You have the right to privacy and the expectation that your personal information will be kept confidential.
* Right to Review**:** You have the right to review you records with the exception of records sent to us by a third party. You will need to contact the sender of those records.
* Right to Participate**:** You have the right to participate in the development of an individualized, person-centered treatment plan. To obtain a copy of your treatment plan, please see your therapist or the office manager.
* Right to Be Informed: You have the right to be informed in advance of potential risks and benefits of treatment, and to consent to or refuse treatment. If treatment is refused we will discuss if other treatment is possible. Refusal of consent shall not be used as the sole grounds for termination/threat of termination of service unless there are no other viable treatment options available. Consent may be withdrawn at any time.
* Right to be Free from Invasion of Privacy and Threat**:** You have the right to be free from unwarranted invasion of privacy and from the threat or fear of unwarranted suspension or expulsion from services.
* Right to Advance Directive**:** You have the right to fill out an Advance Directive, which describes how you want to be cared for if you are ever unable to decide or speak for yourself
* 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.
* Right to Receive Confidential Communication by Alternative Means and at Alternative Locations**:** You have the right to request and receive confidential communications of protected health information by an alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)
* Right to Inspect and Copy**:** You have the right to inspect and/or obtain a copy of protected health information in our mental health and billing records used to make decisions about you for as long as the protected health information is maintained in the record. If you would like a copy of all or part of our records about you, we will copy those pages at a rate of 25¢ per page. We will not permit you to take the record out of this office to copy it. We may deny your access to protected health information 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.
* Right to Amend**:** You have the right to request an amendment of your protected health information for as long as the protected health information is maintained in the record. We may deny your request. On your request we 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 protected health information for which you have neither provided consent nor authorization. On your request, we will discuss with you the details of the accounting process.

Right to a Paper Copy**:** You generally have the right to obtain a copy paper of the notice from us upon Request, even if you have agreed to receive the notice electronically.

Patient’s Rights

I have read, or have had read to me, the Patient’s Right. I have discussed any points that I did not understand, and I have had my questions answered fully.

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Signature of client (or person acting for client) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

Relationship to client

 Self Parent Legal Guardian

Notice of Privacy Practices

This notice describes how mental health and medical information

about you may be used and disclosed. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) imposes numerous requirements on private practitioners concerning the use and disclosure of individual health information. We are required to provide you with this Notice about our privacy procedures. This notice explains when, why, and how we would use and or disclose your personal health information.

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 healthcare operation purposes with your consent. To help clarify these terms, here are some definitions:

* *“PHI”* (Protected Health Information) refers to information in your health record that could identify you.

It can contain data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care.

* *“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. Also, when your therapist is away from the office for a few days, he or she may have asked a fellow therapist to “cover” for him/her. This therapist will be available to you in emergencies. Therefore, he or she needs to know about you. Of course, this therapist is bound by the same laws and rules to protect your confidentiality. We will note all consultations in your clinical record.

* *“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 healthcare or to determine eligibility or coverage.

* *“Health Care Operations”* are activities that relate to the performance and operation of our practice.

Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination.

* *“Use”* applies only to activities within our office such as sharing, employing, applying, utilizing,

 examining, and analyzing information that identifies you.

* *“Disclosure”* applies to activities outside of our office, 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” (also known as a “Release of Information”) is written permission above and beyond the general consent that permits only specific disclosures. This includes times when your records need to be seen by another professional (for example, if you want a physician to have access to the record of your treatment here) or anyone else (for example, if you want a family member to know details about your treatment). 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 we have made about our conversation during a private, group, joint,

Notice of Privacy Practices

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 any authorization to release PHI or psychotherapy notes at any time. Each revocation must be 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 Needing Neither Consent nor Authorization

State and federal laws **require or allow** that we share your health information with others in specific situations without your consent. Prior to disclosing your health information, we will evaluate each request to ensure that only the minimum necessary information will be disclosed. We will ensure any required circumstances for disclosure are met before confidential information is disclosed.

We are required or allowed to disclose health information about you for the following reasons:

* If there is cause to suspect child abuse, neglect, dependency, or death as the result of maltreatment, we must make a report to the Director of the Department of Social Services. In this context, a child is considered “dependent” if he/she has no parent, guardian, or custodian responsible for his/her care, or if the child’s parent, guardian, or custodian is unable to provide for the child’s care or supervision and lacks an appropriate alternative child care arrangement;
* 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 the Department of Social Services.
* To avert a serious threat to your health or safety, or there is a likelihood that you will commit a felony or violent misdemeanor;
* In response to a court order or subpoena;
* For public health activities, such as for the purpose of preventing or controlling disease; For purpose of activities related to monitoring an FDA-regulated product, to a person subject to the jurisdiction of the FDA;
* For health oversight activities, including, but not limited to, civil, administrative, and criminal proceedings;
* To a coroner, for purposes of identifying a deceased person, determining cause of death, or other duties required by law, or to funeral directors so they may carry out their duties;
* To a physician or other health care provider who is providing emergency medical services;
* To determine eligibility for or entitlement to benefits under laws administered by the Secretary of Veterans Affairs;
* For certain military, national security, and intelligence purposes;
* To a correctional institution or other law enforcement official if you are in custody;
* For worker’s compensation purposes;
* To your next of kin, if disclosure about the fact of your admission or discharge is determined to be in your best interest;

Notice of Privacy Practices

* To an internal client advocate, if it is necessary for him/her to perform his/her monitoring and advocacy functions;
* For the purpose of filing a petition of involuntary commitment or a petition for the adjudication of incompetency of the client and the appointment of a guardian, if it is in your best interest;
* To the clerk of court, district attorney or prosecuting officer, and the attorney of record for the client, if you are a defendant in a criminal case and a mental examination has been court ordered;
* To an attorney who represents either Behavioral Health Solutions or one of our employees, if such information is relevant to litigation, the operations of the facility, or to the provision of services by the facility.
* To staff attorneys of the Attorney General’s office when the information is necessary to the performance of the statutory responsibilities of the Attorney General’s office;
* To the Attorney General’s office, if it subpoenas information relevant to a criminal investigation of Medical Assistance provider fraud;
* To another facility when it is necessary to coordinate appropriate and effective care, treatment or habilitation for you;
* To another facility to conduct payment activities, such as providing determination of eligibility or coverage, coordination of benefits, and claim management;
* To fulfill our responsibilities in the your evaluation, management, supervision or treatment if you have been committed to outpatient treatment;
* When Behavioral Health Solutions has entered into a written agreement with someone to provide support services. Anyone providing support services must agree to safeguard and not further disclose this information;
* When an advance instruction for mental health treatment or confidential information from an advance instruction must be disclosed to a physician, psychologist, or other qualified professional to give effect to or provide treatment in accordance with the advance instruction;
* To a physician or treatment provider who referred you to our office;
* To your next of kin, family members with a legitimate role in your therapeutic services, or other person you designate, if they request information about your admission, transfer, discharge, decision to leave treatment, referrals, and appointment information for treatment after discharge. We will disclose this information only after we have notified you that this information has been requested;
* To an area authority or county program that is responsible for administering Medicaid or other sources of public healthcare funding, when the area authority or county program determines that it needs information to develop, manage, monitor or evaluate its network of qualified providers; or
* For general research or clinical, financial, or administrative audits, but only when the client’s identity cannot be identified directly or indirectly in reports from that research or audit.

Notice of Privacy Practices

IV. Our Duties

* We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and

 privacy practices with respect to PHI.

* We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of

such changes, however, we are required to abide by the terms currently in effect.

* If we revise our policies and procedures, we will provide you a copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact us at Behavioral Health Solutions at 919-419-0524. If you believe that your privacy rights have been violated and wish to file a complaint with us, you may send your written complaint to Behavioral Health Solutions, 5318 Highgate Drive, Durham, NC 27713.

You may also send a complaint to the Secretary of the U.S. Department of Health and Human Services.

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

This notice will go into effect on November 19, 2014. We reserve 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 you with a revised notice.

Notice of Privacy Practice

Acknowledgement of Receipt Form

This form, when completed by you, acknowledges that you have received a copy of the Notice of Privacy Practices for Behavioral Health Solutions, P.A.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have received a copy of the Notice of Privacy Practices for Behavioral Health Solutions, P.A. on this date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Representative’s Signature Date

If the acknowledgement is signed by a representative for the patient, the name of the patient and a description of such representative’s authority to act for the patient must be provided.

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Patient’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authority to act for patient (example: parent or legal guardian)