Psychological Services of Charlotte

CHILD

Client Registration Information

Name:_____ Today's Date:_____
(Last,) (First,) (Middle Initial)
Parent's Name:
Mom:_____
Dad:_____
Step Mom (s):_____
Step Dad (s):_____

Age:_____Sex:_____Race:_____ Date of Birth:_____
Social Security Number:_____

Current Address:_____ Phone Numbers:Home:_____
Cell: _____
_____ Work:_____
(City) (State) (Zip) Email:_____

Grade Level:_____ School Attending:_____
Progress/Problems In School:_____
_____

How were you referred to this office?_____
Primary Care Physician:_____Psychiatrist:_____
Emergency Contact:_____Phone#:_____
Address:_____

Insurance Information

Parent Place of Employment:_____
Parent/Policy Holder Social Security Number:_____
Parent Date of Birth:_____

I. Primary Insurance Company_____Phone#:_____
Mailing/Claims Address_____Group#:_____
_____Policy #:_____
Policy Holder:_____Self_____Other:_____Relation to Client:_____
Authorization Number:_____
Policy Holder Social Security:_____Date of Birth:_____
II. Secondary Insurance Company_____Phone#:_____
Mailing/Claims Address_____Group#:_____
_____Policy#:_____
Policy Holder:_____Self_____Other:_____Relation to Client:_____
Authorization Number:_____
Policy Holder Social Security:_____Date of Birth:_____

Informed Consent for Treatment

I give my consent for the staff of Psychological Services of Charlotte to provide a mental health evaluation and appropriate treatment to myself. This consent covers the treatment by my therapist, psychologist or psychiatrist.

Client/ Legal Guardian Initial: _____

Consent for Treatment of Medical and Psychiatric Emergencies

I give my consent for this office to initiate first aide measures, to contact my Primary Care Physician, or alert the emergency medical system. I also consent for my emergency contact to be notified.

Client/ Legal Guardian Initial: _____

Psychological Assessment Fee for Service Agreement

If psychological testing is recommended and agreed upon, I fully understand the psychological assessment is provided at a Fee For Service rate of $180 per hour and $200 per hour for personality tests. By accepting this agreement, I agree that **neither PSC nor I will bill** the insurance/managed care company for the payment of these services.

Client/ Legal Guardian Initial: _____

Missed Appointment

Psychological Services of Charlotte requests that in the event you are not able to make an appointment for whatever reason, that you cancel the appointment with 24 hours prior to that appointment to maximize appointment times for all other clients. Please be aware that failure to do so will result in a $75 fee that is not reimbursable by any insurance company and therefore is your direct responsibility.

Client/ Legal Guardian Initial: _____

Returned Checks

A check returned for insufficient funds will convert into an **electronic transaction** through the Automated Clearing House (ACH) network. Your account will be debited for the face amount of the check plus the returned check fee of $25. A limit of 2 occurrences applies prior to checks no longer being accepted at PSC for payment.

Client/ Legal Guardian Initial: _____

****I have read, understand, and agree to all of the above information****

Client/Legal Guardian Signature:_____ **Date:**_____

Financial Policy/Agreement

- Information we receive from your insurance company is strictly an estimate of benefit and not a guarantee of payment. Your co-pay, deductible, and/or cost share amounts, as well as any non-covered services from your visit, are due at the time of service. I understand that I am ultimately financially responsible for all charges and fees related to the treatment rendered to me at Psychological Services of Charlotte.
- I understand that the filing of any medical insurance claims is a courtesy Psychological Services of Charlotte extends for convenience, and I am ultimately responsible for the charges and authorizations with my insurance company.
- I understand that it is my responsibility to provide updated insurance information in a timely manner. Not doing so could result in charges being denied and I am ultimately responsible for the balance due.
- I authorize payment of medical benefits to Psychological Services of Charlotte for services rendered.
- If I feel that my claim has been inaccurately denied for something other than error on Psychological Services of Charlotte's behalf, it is my responsibility to dispute this directly with my insurance provider. I will be responsible for any remaining balance on my account at that time. If the claim is later resolved by my insurance provider, Psychological Services of Charlotte will refund any amount due.
- I am responsible for obtaining a referral/authorization if my insurance provider requires a referral/authorization in order to be seen in the office. Referrals/authorizations not obtained within 5 business days prior to the visit will require the full amount of the visit to be paid in full at that time.
- If new insurance is presented at the time of the appointment and takes longer than 15 minutes to verify, I will be given the option of paying for services in full or rescheduling the appointment. If insurance benefits are verified once I have been seen and payment has been made, Psychological Services of Charlotte will file the claim and reimburse the remaining difference.
- I understand that not all insurance companies coordinate benefits with one another. It is my responsibility to let staff know when checking in for my appointment in order for benefits to be applied to that visit.
- If payment from my insurance provider has not been received within 60 days from the initial filing date of claim, it is my responsibility to pay my account balance in full.
- I authorize the release of any medical information necessary to process claims for services rendered.
- It is our office's policy to send accounts over 120 days to the collection agency of our choice.
- I understand that if my account is assigned to an attorney for collection and/or suit, Psychological Services of Charlotte shall be entitled to reasonable attorney's fees and costs for collection, and that information regarding my account may be released.

Method of Payment

Psychological Services of Charlotte will **ONLY** accept cash, Visa, MasterCard, American Express, Discover, Personal Checks, or Money Orders.

Personal Information

Please take a moment to help us better understand your situation by filling out these questions. *Please know that this information will be highly respected as part of your protected health information, and will be a part of your* ***confidential*** *file.* We thank you for choosing Psychological Services of Charlotte, and we trust we may be able to meet your psychological needs.

Reason to today's visit:_____

_____

Do you see yourself/your child as struggling with:_____Depression _____Anxiety
_____Anger _____Family

Problems: _____Substance Use Problems
_____Other:_____

Who do you/your child live with:_____

Any major medical problems:_____

Current Medications/Doses: 1)_____2)_____

3)_____4)_____

Have you/your child experienced therapy before:_____Never
_____Yes: How many Therapists:_____

Have you/your child been admitted to a hospital for psychiatric reasons:
_____Never
_____Yes, how many times:_____

What are your main goals for therapy:

1)_____

2)_____

3)_____

****Thank you for your time, effort and patience with all this needed paperwork. Your doctor/therapist will be with you shortly.****

Psychological Services of Charlotte, Inc.

Notice of Privacy Practices

this Notice is effective 2/1/06

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

*****We are required by law to protect health care information about you*****

The following information is provided to you as we are required by law to do so; and we desire to provide you services while you are in full understanding of the legal aspects of doing so. We aspire to protect your health care information and information that may identify you. Please know and understand that we are legally bound to the information provided to you here. We are only allowed to use and disclose health care information in the matter that we have described in this notice.

The officials of Psychological Services of Charlotte, Inc. want you to feel comfortable asking questions about anything unclear to you in this notice. Please do so by contacting the privacy officer or any of the partners of this corporation.

Information regarding your health care at Psychological Services of Charlotte, Inc. is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 42 USC 1320 et seq., 45 CFR Parts 160 & 164 and, when applicable, Federal Drug and Alcohol Confidentiality, 42 USC 290dd-2, 42 CFR Part 2; and North Carolina Mental Health, Developmental Disabilities and Substance Abuse Laws (NCGS 122-C-52 through 122C-56). Under these laws, Psychological Services of Charlotte, Inc. may not say to person outside PSC that you attend the agency, nor disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected health information except as permitted by the state and federal laws listed above or with your written authorization.

I. We use and disclose health care information for you for **treatment, payment, and healthcare operations.**

A. Treatment

We may use and disclose health care information about you to provide health care treatment to you in order to provide, coordinate or manage your health care and related services. This may include communication with other health care providers within this corporation and with

providers the corporation contracts with to provide services to you regarding your treatment and coordination and managing your health care.

We may use and disclose health care information about you in order to inform you of, or recommend new treatment, or different methods for treating a health care condition that you have, or to inform you of other health-related benefits and services that may be of interest to you.

B. Payment

We may use and disclose health care information about you with your written consent to obtain payment for health care services that you received. This includes disclosing protected health information to your health insurer to obtain reimbursement and/or determine eligibility or coverage.

C. Health Care Operations

Health care operations include a variety of business activities. These activities include: providing training programs to other professionals or providers, business audits and other administrative services, planning for our organization's future services, and working with other professionals such as lawyers, accountants, or other consultants.

D. As Required by Law

These laws are cited and explained within this notice, for instance, in the event that abuse and/or neglect of a minor or elderly person is known by your therapist or doctor.

E. Persons Involved in Your Care

We may disclose information about you to a relative, close personal friend or any other person you identify as consent to in writing if that person is involved in your care (or responsible for your care) and the information is relevant to your care. We may contact you to provide you notice of your next appointment or circumstances that may require rescheduling or changing of your appointment.

II. Uses and Disclosures without consent or Authorization

The laws cited previously designate certain situations as "national priority." This refers to instances deemed important to disclose health care information without consent. They are:

A. Threat to health or safety: when it is necessary to prevent or lessen a serious threat to your health and safety or the health and safety of someone else. This also applies when we need to report a crime against our personnel or medical personnel in a medical emergency.

B. Public Health Activities: these activities include but are not limited to activities related to investigation diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the FDA, and monitoring work related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.

C. Abuse, Neglect, or Domestic Violence: for children or older adults. We are required by law to inform a governmental authority (such as the Department of Social Services) if it can be reasonable believed to be a situation where a child or elderly adult has been neglected, abused, or a victim of domestic violence.

D. Court Proceedings: when a valid court order from a judge is presented we are forced to disclose health care information about you.

E. Law Enforcement: if a law enforcement officer has a court order to take you into custody, for instance, during an involuntary commitment for mental health needs, we are permitted to disclose to the officer information about your mental state when necessary to assure your health and the safety of others.

F. Coroners and others: we are permitted to disclose health care information to a coroner or medical examiner which may be relevant to determine the cause of death and manner or death when required by law to do so.

G. Workers' Compensation: we may disclose health care information about you in order to comply with workers' compensation law.

H. Research: PSC, if engaging in research, will only disclose protected health care information when stringent conditions about protecting the privacy of the information are satisfied.

III. Uses and Disclosures Requiring Consent/Authorization

Most of the information that is in your medical record with us is protected and illegal for us to share with anyone. If you are a minor we are permitted to share the information only with your legal guardian. Please also note, though, that when you are a minor we are not allowed to share any information about substance use/abuse even with your guardian.

A. Authorization: In order for us to share information other than for the reasons listed above we are required to obtain your signature or the signature of your legal guardian that includes specific information about how, when, and what we will disclose. This is the case for when we want to release information or in the case you want us to disclose information.

B. Revocation of the Authorization: You may later revoke the above authorization at any time after you sign it. This must be done in writing via a letter or memo with your signature included.

IV. Client's Rights and PSC's responsibilities.

A. Your Rights (client's rights)

1. Right to a copy of this notice:

2. Right of access to inspect and copy: you have a right to review and receive a copy of your health information that we maintain in certain groups of records. This right can be denied if it is deemed that the information or part of the information will place you or someone else at risk for harm. This right may also be denied if the information was received from someone else, other than a health care provider, if he or she requested that it remain confidential. If this denial occurs you may require the request be reviewed by the corporation privacy director or any other corporation partner. We must respond to this request in writing within 30 days of receipt of the request.

3. Right to have health care information amended: you have the right to question the accuracy and completeness of health care information about you that we maintain in certain groups of records and have the right to have us amend (correct or add to) the health care information. This

must be requested in writing. We must act on this request within 60 days after the receipt of the request.

4. Right to have an accounting of disclosures we have made: you have the right to receive a detailed list of disclosures we have made for the previous six (6) years of today's date.

5. Right to request restrictions: you have the right to request further limitations to the use of your protected health information; though please note, we are not required to agree to this request (though we will reasonable do so).

6. Right to request an alternative method of contact: you have the right to be contacted at a different location or by a different method. For example, you may prefer to have your bill be mailed to another address other than your home.

B. PSC's Responsibilities:

1. We are required by law to maintain the privacy of your protected health information and provide you notice of our responsibilities and privacy practices.
2. We have the right to change our privacy policies and practices. If we change them, we will provide you with an updated privacy notice on your next date of service, by mail, or in person whatever is sooner. Until you receive an updated privacy notice, we will follow the practices of this notice.

V. You may file a Complaint about our privacy policies

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a complaint either with us or with the federal government. You may do this by contacting our privacy officer or the governmental authority you deem appropriate. The privacy officer can help you further with this should the need arise.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of Psychological Services of Charlotte, Inc. Notice of Privacy Practices.

_____ or _____
Print Name Print Guardian Name

_____ _____
Signature Date signed/received

_____

_____

The following is for PSC Internal use only

PSC attempted to obtain acknowledgment of receipt of Notice of Privacy Practices. Acknowledgement could not be obtained as specified below:

_____ Individual refused to sign

_____ An emergency situation prevented obtaining the acknowledgment. The Notice of Privacy Practices will be provided an acknowledgement obtained as soon as it is reasonable practicable to do so.

_____ Other (Please Specify) _____

_____

_____ Individual agreed for PSC to mail a copy of the Notice of Privacy Practices. Record date, address and to who the Notice was mailed:

_____

_____

STAFF SIGNATURE:_____ DATE:_____