Client's Name: _____ Sex: [] Male [] Female [] Unknown

Date of Birth: _____ Social Security Number: _____

Marital Status: [] Single [] Married [] Separated [] Divorced [] Widowed [] Life Partner [] Common Law Spouse

Race: [] African American [] Alaska Native [] American Indian [] Asian [] Caucasian [] Chinese [] Filipino [] Guamanian/Chamorro [] Hawaiian [] Japanese [] Korean [] Pacific Islander [] Samoan [] Vietnamese – [] Multi-racial [] Bi-racial [] Declined

Ethnicity: [] Hispanic/Latino [] Not Hispanic/Latino [] Declined

Address: _____ Phone: _____

City, State, Zip: _____

Preferred method of Appointment reminders:
Circle preference and fill in information clearly:

Text: (____) _____

Voice: (____) _____

Email: _____

Employment Status:
[]Active Duty Military [] Full Time
[] Part Time [] Not Employed [] Retired

Place of Employment:

_____

Emergency Contact/ Primary Care Physician:
Emergency Contact: _____ Relationship: _____
Phone Number: _____
Primary Care Physician/Facility: _____
Phone Number: _____

Reason seeking treatment (i.e. anxiety, depression, suicidal, self-harm, substance abuse, marital problems, DOT Evaluation, substance abuse group, etc.)

_____

Are you requesting a male or female provider: Circle one: Male Female No preference

Insurance Information:

TRICARE CLIENTS MUST INCLUDE SPONSOR'S SSN & DATE OF BIRTH.

ACTIVE DUTY TRICARE MUST HAVE REFERRAL FROM PRIMARY CARE PROVIDER

For Office Administration Only: [Updated: 11-15-19]

Client Name: _____ Date of Birth: _____

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EVERYTHING IN BOLD, MUST BE FILLED OUT FOR EACH INSURANCE POLICY

**PRIMARY INSURANCE POLICY

Name of Policy Holder: _____ **Relationship:** _____

DOB of Policy Holder: _____ **SSN of policy holder**: _____

Insurance Company: _____ **Phone # of policy holder**: _____

Policy # for client being seen: _____ Group#: _____

Subscriber #: _____

Address of Policy Holder if different from above: _____

**SECONDARY INSURANCE POLICY

Name of Policy Holder: _____ **Relationship:** _____

DOB of Policy Holder: _____ **SSN of policy holder**: _____

Insurance Company: _____ **Phone # of policy holder**: _____

Policy # for client being seen: _____ Group#: _____

Subscriber #: _____

Address of Policy Holder if different from above: _____
_____

****Distinguishing between the primary and secondary insurance plans in extremely important when filing multiple insurances. If the wrong insurance is billed first, the claim will be denied.**

Authorization to Pay Healing Minds Therapeutic Services, PLLC

I, _____, authorize payment directly to Healing Minds Therapeutic Services, PLLC. I agree to be fully responsible for all lawful debts incurred by myself or my legal dependents listed above for services received from Healing Minds Therapeutic Services, PLLC whether covered by insurance or not. I authorize the release of any information necessary to process claims on my behalf or on the behalf of my legal dependents listed above. I further understand that I am responsible for any co-pay, co-insurance, and/or deductible amount as per my particular insurance coverage on my account and I understand that although my claims are filed, it is not a guarantee of payment for services.

Signature of client/legal guardian: _____ Date: _____

For Office Administration Only: [Updated: 11-15-19]

Client Name: _____ Date of Birth: _____

Medicaid #: _____ Chart #: _____

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Legally Responsible Person for Minor Child

<u>This portion is to be completed only if the consumer is a minor child under 18 years of age or is an adult with a legally responsible person.</u>

Parent/Legally Responsible Person's Name: _____ Relationship: _____

Address (if different from minor child's address): _____

Contact Numbers: _____ / _____ / _____
Primary Secondary Work

Is DSS currently involved? [ ] Yes [ ] Case Worker Name: _____

Case Worker Phone Number: _____

Is there more than one legally responsible person? Yes [ ] No [ ] (If yes, please complete the following)

Parent/Legally Responsible Person's Name: _____ Relationship: _____

Address (if different from minor child's address): _____

Contact Numbers: _____ / _____ / _____
Primary Secondary Work

Is there a custody or adoption order for this minor child? Yes [ ] No [ ] (If yes, you will be required to provide a copy).

What school does the minor child attend? _____ Grade: _____

Foster Parent's Name (if applicable): _____ Number: _____

Foster Care agency/Facility (if applicable): _____ Number: _____

SIGNED INFORMED CONSENT FOR PARTICIPATION IN ASSESSMENT & TREATMENT

On behalf of myself, or client **if a minor**, I hereby agree to the following conditions of participation in assessment and treatment:

1. **Voluntary Participation:** I voluntarily consent to participate in such counseling services as may be deemed necessary and appropriate by the staff of Healing Minds Therapeutic Services, PLLC. I understand that I will be kept informed of plans for my treatment and may withdraw my consent in writing at any time. I am aware that the practice of counseling is not an exact science and I acknowledge that no guarantees have been made as to the effectiveness of the treatments and assessments.
2. **Confidentiality:** I give permission for the office staff of Healing Minds Therapeutic Services, PLLC to provide clinical information to my insurance or its designee at their request, for the purpose of justifying my need for treatment and/or continued treatment. Other verbal and written information regarding my treatment is protected by Federal law and regulations and may be released **only** with my specific written consent to qualified personnel for research, audit or evaluation purposes, or when the opinion of clinical staff deem there is a medical emergency and release of information would in my behalf, aid in my treatment, or protect the safety of myself and/or others by court order. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a client either at the program, or against any person who works for the program, or about any threat to commit a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State and local authorities.

Client's Printed Name: _____ Check if Client is a Minor [ ]

Signature of Client or Guardian: _____ Date: _____

Follow-Up Protocol: I agree that the office staff members of Healing Minds Therapeutic Services, PLLC may call or write if I fail to keep an appointment in order to assess my need for further treatment. I also agree the office staff members of Healing Minds Therapeutic Services, PLLC may contact me via letter after I have completed treatment in order to obtain information about the quality and effectiveness of the services, I received at Healing Minds Therapeutic Services, PLLC.

I agree to above follow-up protocol: Yes [ ] No [ ] Client Initials: _____ Date: _____

Should you need emergency psychiatric services after normal operating hours of Healing Minds Therapeutic Services, PLLC, you can call 911 or the nearest emergency services.

24 Hour Crisis Line: 910-489-4962

For Office Administration Only: [Updated: 11-15-19]

Client Name: _____ Date of Birth: _____

Medicaid #: _____ Chart #: _____

MRN #: _____ Date of Registration: _____

CONSENT FOR EMERGENCY TREATMENT

I, _____(print name), the [] consumer, [] parent, [] legally responsible person:

A: give my written consent for this Agency to provide assessment, treatment and/or other services for the above-named consumer. I reserve the right to withdraw consent at any time. I also reserve the right to refuse, at any time, any services offered. I understand that my signature constitutes my permission for this Agency to provide treatment for all beneficiaries of all ages. (Initial)_____

***Source**: Clinical Coverage Policy 8C, "consent at the time of the initial service, the provider shall obtain the written consent from the legally responsible person for treatment for beneficiaries of all ages".*

B: understand that written consent for treatment is obtained prior to treatment services, and that I grant permission for this Agency to seek emergency medical care from a hospital or physician. (Initial) _____

***Source**: APSM 45-2, "written consent for the provider to provide [authorized] treatment is obtained prior to treatment services and shall be signed by the individual and/or legally responsible person." This code further states that a written consent that grants permission to seek emergency medical care from a hospital or physician shall be obtained from the individual or legally responsible person.*

C: understand that the following emergency information for the client will include the name, address and telephone number of the person to be contacted and the name, address and telephone number of the physician to be contacted. (Initial) _____

***Source**: North Carolina Administrative Codes, "a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician". This code further states that emergency information for clients shall include the name, address and telephone number of the person to be contacted in case of a sudden illness or accident and the name, address and telephone number of the client's referred physician and/or hospital.*

Person to be contacted: _____

Address: _____ Phone Number: _____

Preferred Physician: _____

Address: _____ Phone Number: _____

Preferred Hospital: _____

Address: _____ Phone Number: _____

I have read, understand, and initialed A, B, & C above: _____

Signature: Consumer, Parent, LRP Date

[] I CHOOSE NOT TO SIGN this consent for emergency treatment form, yet I will still receive treatment

_____

Signature: Consumer, Parent, LRP Date

References:
10 A NC Administrative Code 27G .0206 (6) [Client Records]/ NC DHHS: APSM 45-2, dated July 1, 2016/ NC Medicaid and Health Choice Clinical Coverage Policy 8C Section 7.2.1, dated March 15, 2019

For Office Administration Only: [Updated: 11-15-19]

Client Name: _____ Date of Birth: _____

Medicaid #: _____ Chart #: _____

MRN #: _____ Date of Registration: _____

HIPAA Privacy Rules: Protection of Health and Mental Health Information
(45 CFR Parts 160 and 164)

The information provided below is a summary and intended for general information purposes. Information on HIPAA is also found in our Consumer's Rights Handbook, which can be found at the front desk. You can request a copy of this notice and/or the Consumer's Right's Handbook upon request.

The HIPAA Privacy Rule (45 CFR Parts 160 and 164- (164.524; 164.528; 164.508; 164.512a) provides the first comprehensive Federal Protection for the privacy of health and mental health information. The rule is intended to provide strong legal protections to ensure the privacy of the individual health information and mental health information, without interfering with the patients access to treatment, health care operations, or quality of care. The Privacy Rule applies to 'covered entities' which generally includes health plans and health care providers who transmit health information in electronic form. Covered entities include almost all health and mental care providers, whether they are outpatient, residential or inpatient providers, as well as other persons or organizations that bill or are paid for health care.

" Minimum Necessary" Rule:

A covered entity must make responsible efforts to use, request, or disclose to others only the minimum amount of Protected Health Information (or PHI) which is needed to accomplish the intended purpose of use, request or disclosure. When the minimum necessary standard applies, a covered entity may not use, disclose, or request a person's entire medical record unless it can be specifically justified that the entire record is reasonably needed. The minimum necessary standard does not apply under the following circumstances:

a. Disclosure to a healthcare provider for treatment;
b. Disclosure to an individual (or personal representative) who is the subject of the information;
c. Use or disclose made pursuant to an Authorization by the person (or personal representative);
d. Use or disclosure that is required by law; or
e. Disclosure to Health and Human Services (or HHS) for investigation, compliance

Basic Principles of the Privacy Rule:

1. The Privacy Rule protects all 'protected health information (PHI),' including individuality identifiable health or mental health information held or transmitted by a covered entity in any format, including electronic, paper, or oral statements.

Client Name: _____ Date of Birth: _____

Medicaid #: _____ Chart #: _____

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a. A major purpose of the Privacy Rule is to define and limit the circumstances under which individual's PHI may be used or disclosed by covered entities. Generally, a covered entity may not use or disclose PHI to others, except: as the Privacy Rule permits or requires or as authorized by the person (or personal representative) who is the subject of the health information. A HIPAA-compliant Authorization must contain specific information required by the Privacy Rules.

2. A covered entity must provide individuals (or their personal representatives) with access to their own PHI (unless there are permitted grounds for denial) and must provide an accounting of the disclosures of their PHI to others upon their request.
3. The Privacy Rules supersedes State law, but State laws provide greater privacy protections under which give individuals greater access to their own PHI remain in effect.

Permitted Uses or Disclosures of PHI Without Authorization

1. A covered entity may disclose PHI **to the individual who is the subject of the information.**
2. A covered entity may use and disclose protected health information for its own '**treatment, payment and health care operations.'**
   a. **Treatment** is the provision, coordination, or management of healthcare and related services for an individual, including consultation between providers and referral of an individual to another provider for health care.
   b. **Payment** includes activities of a health care provider to obtain payment or receive reimbursement of the provision of health care to an individual.
   c. **Health care operations** include functions such as: (a) quality assessment and improvement; (b) competency assessment, including performance evaluation, credentialing, and accreditation; (c) medical reviews, audits, or legal services; (d) specified insurance functions; and (e) business planning, management, and general administration.
3. **Permission may be obtained from the individual who is the subject of the information** or by circumstances that clearly indicate an individual with the mental capacity can object to the disclosure but does not express an objection. Providers may also rely an individual's informal permission to disclose health information to an individual's family, relatives, close personal friends or to other persons identified by the individual, limited to the information directly related to such person's involvement.
4. When an **individual is incapacitated** or **in an emergency,** providers sometimes may use or disclose PHI, without authorization, when it is in the best interests of the individual. Such as determined by health care providers in the exercise of clinical judgment. The PHI that may be disclosed under this provision includes the patients name, location in a health care providers facility, and limited and general information regarding the person's condition.
5. Providers may use or disclose PHI without a person's authorization when the disclosure of PHI is **required by law,** including State statute or court order.
6. Providers generally may disclose to State and Federal **public health authorities** to prevent or control, injury, or disability, and to government authorities authorized to receive reports on child abuse and neglect.
7. Providers may disclose PHI to appropriate government authorities in limited circumstances regarding **victims of abuse, neglect, or domestic violence.**
8. Providers may disclose PHI to **health oversight agencies,** (e.g.., the government agency which licenses a provider), for legally authorized health oversight activities, such as audits and investigations.

9. PHI may be disclosed in a **judicial or administrative proceeding** if the request is pursuant of court order, subpoena, or other lawful process (Note: the 'more stringent' NYS Mental Hygiene Law requires a court order for the disclosure of mental health information in these circumstances).
10. Providers may generally disclose PHI to **law enforcement** when:
    a. Required by law, or pursuant to a court order, subpoena, or an "administrative request,' such as a subpoena or summons (Note: the 'more stringent' NYS Mental Hygiene Law Section 33.13 requires court order for the disclosure of MHI in these circumstances).
    b. In response to a law enforcement request for information about a victim of a crime (Note: under Mental Hygiene Law Section 33.13 this information is limited to "identifying data concerning hospitalization."
    c. To alert law enforcement about criminal conduct on the premises of a HIPAA covered entity.
    d. Providers may disclose PHI that they believe **necessary to prevent or lessen a serious and imminent physical threat** to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat).
    e. Programs involved in the sharing of information is required or expressly authorized by statute or regulation, or other limited circumstances.

Complaints to: Office for Civil Rights Department of Health and Human Services, Atlanta Federal Center, Suite 3B70 61 Forsyth Street, S.W. Atlanta, GA 30303-8909. Web site at: https://www.hhs.gov/hipaa/filing-a-complaint/index.html?language=es

I HAVE READ AND UNDERSTAND MY RIGHTS UNDER THE HIPAA GUIDELINES.

Client or Responsible Party Signature: _____ Date: _____

For Office Administration Only: [Updated: 11-15-19]

Client Name: _____ Date of Birth: _____

Medicaid #: _____ Chart #: _____

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Fees for Services Performed Outside of Counseling

Payment for services at Healing Minds Therapeutic Services, PLLC are due when services are provided. As a courtesy to our clients and families, we will bill your insurance company in accordance with the information you provide to us. It is your responsibility to keep Healing Minds Therapeutic Services, PLLC staff informed of any changes to your insurance coverage. You are obligated to pay and deductible or copay required under your insurance plan, at the time of service.

Charges are based on the type of services provided to you. If additional time or services, (such as telephone sessions or reports) are provided, a pro-rated fee will be charged. You remain legally responsible for all charges.

Below is a list of common services and fees that clients may encounter. Your provider will discuss these fees with you at the time of the request.

Letters/Reports for your insurance company or another agency	$150 per hour
Court related costs: letters, testimony, forensic reports, etc. (Costs for testifying include travel time "door-to-door"."	$175 per hour
Services that are not covered by your insurance company: (Certain types of testing, phone sessions, etc.)	$150 per hour

You will be charged for all missed appointments. With sufficient notice, an appointment can generally be rescheduled. Failure to give 24-hour notice of cancellation will result in a 'NO-SHOW' charge of $25.00.

Note: Per CMS rules, Medicaid recipients will not be charged 'no-show' fees but will be responsible for other fees contractually agreed to.

This financial relationship will continue as long as we provide services or until such time as you notify us that you wish to terminate treatment. Once treatment terminates, any balance not paid in full will be considered due immediately. When an account becomes 60 days past due, professional collections may be utilized, and/or legal action may be taken.

My signature below indicates that I have read and understand this fee policy. I agree to take full responsibility for fees charged to my account.

Signature: _____ Date: _____

Client Name: _____

For Office Administration Only: [Updated: 11-15-19]

Client Name: _____ Date of Birth: _____

Medicaid #: _____ Chart #: _____

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Consumer Acknowledgment of Information Received

Please review the Consumer Rights Handbook, which provides important information about your rights as a consumer, notifications of the 24 hour Crisis Coverage Policy, responsibilities/rules to follow and possible penalties for violations, the procedure to obtain a copy of your treatment/service plan, your right to contact Disability Rights NC if you have a complaint, and your right to Protection of Health Information (PHI) covered under HIPAA laws.

CONSENT FOR TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES: I voluntarily consent to participate in professional counseling services as may be deemed necessary and appropriate by the clinical staff at this Agency.

ATTENDANCE/APPOINTMENTS: By signing below, you are indicating you understand that it is your responsibility to keep all scheduled appointments (group, individual, family, team meetings) if possible. If you are unable to keep your scheduled appointment, you are to make efforts to call this office or your assigned counselor prior to the appointment. Your counselor will ultimately determine if the cancellation is 'excused' or 'unexcused'. If you have more than 3 unexcused absences, then you are subject to likely termination from the program and will be discharge as 'unsuccessful'. You will be given several other provider resources to contact to continue your care.

HIPAA (NOTICE OF PRIVACY PRACTICE): This Agency is required by the Health Information Portability and Accountability Act (HIPAA) of 1996 to maintain the privacy of your health information as stated in our Notice of HIPAA Privacy Practices. I acknowledge that I have been informed by the Privacy Practices for this Agency.

CLIENT RIGHTS AND RESPONSIBILITIES/CODE OF ETHICS: I attest and acknowledge that I have been given a copy of the handbook entitled 'Consumer Rights Handbook' for this Agency, and it is to be kept for my personal use. I have read it, or had it read to me. My questions regarding my rights have been answered and I understand my rights as a consumer of this Agency. I understand that the handbook provides information about my rights and responsibilities as a consumer and does not constitute legal advice or findings with respect to those rights and responsibilities and should not be considered as granting or denying any right guaranteed by law. The ethical guidelines governing the Mental Health Substance Abuse Profession are established to ensure that the highest standards are followed for the professional practice.

CONFIDENTIALITY: The confidentiality of patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a person attends this program, or disclose any information identifying a patient as an alcohol or drug abuser unless the patient consents in writing. Federal laws require or allow that we can share your health information including alcohol and drug abuse records with others, in specific situations in which you do not have to give consent, authorization or can agree or object to the disclosure. These situations include, but are not limited to the following: 1) to county DSS or law enforcement to report abuse, neglect or domestic violence; 2) to respond to court order or subpoena; 3) to appropriate authorities if we learn that you might seriously harm another person or property in the future or that you intend to commit a crime of violence or that you intend to self-harm; 4) purpose of internal communications as outlined above; 5) to qualified service organization agencies when appropriate; 6) the disclosure is made to medical personnel in a medical emergency or 7) to qualified personnel for

Client Name: _____ Date of Birth: _____

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research, audit or program evaluation. I acknowledge receipt of this notice of confidentiality of my presence in this program and the confidentiality of my records.

ORIENTATION TO FACILITY & 24-HOUR CRISIS COVERAGE: I acknowledge that I have been made aware of all safety exits, public restrooms and can request assistance if necessary. I am also aware that I may access this Agency in a crisis situation by calling 910-489-4962.

FOLLOW-UP: I agree staff members may contact me by telephone or by letter after discharge for the purpose of tracking progress/outcomes.

I attest that I have been provided information regarding how to file a complaint with the NC DHHS Complaint Hotline: 1-800-624-3004 (within N.C.) or 919-855-4500 or with the Secretary of DHHS at 200 Independence Avenue S. W. Washington, DC 20201 or by calling 877-696-6775.
Also, complaints can be made by calling the Office of Civil Rights at 800-368-1019 and/or Disability Rights North Carolina at 877-235-4210 to file a complaint regarding Rights of Individuals with Disabilities.

My signature below confirms I have received and reviewed the Consumer Rights Handbook, which outlines this Agency's policies and practices as summarized above.

_____ Date: _____

Signature of Consumer or Legally Responsible Person

For Office Administration Only: [Updated: 11-15-19]

Client Name: _____ Date of Birth: _____

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