PRESBYTERIAN COUNSELING

DATE:_____

## Personal Information for Adult and/or Guarantor

***(Please print and complete all requested information on front and back of this form)***

Name:_____Name You Prefer_____

Address:_____City:_____State:_____Zip:_____

Sex: M_____F_____ Age _____Birth Date ____/____/_____ Soc. Security No. _____ /_____ /_____

Status (Please Circle): Single Married Separated Divorced Partnered Widowed

Name and Age of Children: _____Age____, _____Age_____,

_____Age___, _____Age, _____Age___

_____Employed _____Unemployed Employer _____Occupation_____

Religious Affiliation_____Congregation Name_____

**List of Physicians you have seen in the last 24 months:_____**

Previous Psychiatrist / Counseling ? _____Yes _____No If yes, When___/____/____ With Whom _____

Concerns that bring you here_____

***ANY KNOWN DRUG ALLERGIES:_____***

***Prescription and non-prescription medications you take_____***

---

Amount of Alcohol (Beer, Wine, Mixed Drinks) you use each day_____Week_____

**Who Referred you?** Please check appropriate referral

Medical Provider_____Internet_____ Church_____Insurance Co_____ Previous Client_____ Other _____

Other_____ (Specify name of referral)

May we call you? _____Home_____Work_____Other_____

Home Phone ( ) _____ Work Phone ( ) _____Ext No. _____ Other_____

When is the best time to reach you? Time: _____ Days_____

**Emergency contact:_____ phone number_____**

## PRIMARY INSURANCE

Name of Policy Holder_____ Relationship to client_____

Policy Holder's Birth Date_____ _____ _____ Social Security No. _____ _____ _____

Employer Name and Address_____

Employer's phone (  )_____

Insurance Company Name and Address _____

Insurance Company phone (  )_____

Policy No. _____ Group No._____

## Secondary Insurance

Name of Policy Holder_____ Relationship to client_____

Policy Holder's Birth Date_____ _____ _____ Social Security No. _____ _____ _____

Employer Name and Address_____

Employer's phone (  )_____

Insurance Company Name and Address _____

Insurance Company phone (  )_____

Policy No. _____ Group No. _____

### Responsible Party Other Than Client

Name and Address_____

Relationship_____ Employer _____

Work Phone (  )_____ Home Phone (  )_____

### Rights and Responsibilities

The purpose of counseling is to help you clarify your goals and to achieve greater understanding and skills so you can reach your goals. Much of the success of counseling will depend on your willingness to participate fully in the process of developing goals that are significant to you. Your therapist's role will be to help you develop options for how you want to reach your goals. If you feel dissatisfied with any part of our work together, please let your therapist know immediately so your therapy will be as productive as possible. If you believe you have been treated unethically, by any counselor, and cannot resolve this issue with that person, you may contact the North Carolina Board of Licensed Professional Counselors at (919) 661-0820, North Carolina Marriage And Family Therapy Licensure Board (336) 794-3891, or North Carolina Social Work Certification and Licensure Board (800) 550-7009 or (336) 625-1679 for clarification of your rights or to lodge a complaint.

### Authorization for Insurance & Consent for Services

I, the undersigned, have insurance coverage with _____ and assign directly to Presbyterian Counseling Center all medical benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance company. I hereby authorize Presbyterian Counseling Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I hereby give my consent for treatment for myself and/or my child for services to be provided by Presbyterian Counseling Center. I understand that I may discontinue at any time. I have read the Presbyterian Counseling Center Information sheet and certify that the above information is correct.

_____ _____ _____ _____

Signature of Insured/Guardian/Responsible Party Date

Revised 3/2018

# Presbyterian Counseling Center
# HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Healthcare Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family or other contact? YES NO

If YES, please name them members allowed:

| Name | Relationship | Date |
|---|---|---|
| Name | Relationship | Date |
| Name | Relationship | Date |

This consent was signed by:

Print name please

Signature:

Date

Witness:

Date

Revised 1/2018

# Presbyterian Counseling Center
## Privacy Practices

This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### Your Mental Health Information Rights

***Request Restrictions***: You may request further restrictions on our uses and disclosures of your mental health information. We may not be able to agree to all requested restrictions. Please let us know if you want specific restrictions on your information.

***Different Ways to Communicate***: We will usually communicate by mailing or phoning your residence. However, you may prefer a different way for us to contact you. For example, you may ask for us to contact you at a specific address or phone. Please note that cell phones and e-mail may not offer confidentiality or privacy protection.

***Right to Inspect and Copy Information***: You may inspect and copy your mental health information. We may charge for copying. To inspect or copy your mental health information, you must make your request in writing to the Privacy Officer. There are situations in which we do not have to comply with your request. However, we will state in writing if we cannot comply with a request.

***Right to Request Amendment of Your Information***: You may request that your mental health information be amended or changed. We may deny your request if we did not create the information (it was obtained from another source). Also, we may deny your request if we believe the information is correct. Denials will be written and will describe your rights for further review. If we agree to amend, we will make reasonable efforts to share with any person who may have received your mental health information that it needs amending.

***Listing Of Disclosures We Have Made***: You may request a copy of certain disclosures we have made of your mental health information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request in writing to our Privacy Officer.

***Copy of This Notice***: You may request a copy of this notice at any time. A copy is available at our web site, www.greensboro.com/pcc

### How Your Mental Health Information May be Used

Except for the following purposes, we will use and disclose your mental health information only with your written permission. You may revoke such permission at any time by writing our Privacy Officer.

***Treatment***: We may use your information and disclose it to manage or coordinate treatment provided to you. For example, your therapist may share information with another therapist or your physician to coordinate services

***Payment***: We may use and disclose necessary information about you to obtain payment for our services. For example, this information could include information that your health insurance plan may require before it approves or pays for treatment services we recommend for you.

***Health Care Operations**:* We may need to use or disclose information for our practice activities. Examples of these activities include: quality assessment to see how well we are doing in serving individuals, couples, and families; clinical supervision of staff to meet state licensure and/or certification requirements.

We may use or disclose information about you in several other circumstances in which you do not have an opportunity to agree or object. These situations include:

***Required by Law**:* We may need to disclose information for judicial or other administrative proceedings. For example, we may need to disclose information in response to a court order.

***Abuse or Neglect***: We are required to disclose information if we believe that you or a family member has been a victim of abuse or neglect

***Danger to Self or Others***: We are required to take steps to prevent you harming yourself or another person.

***Law Enforcement***: We may be required by a law enforcement official to provide information if it is in response to a court order, subpoena, warrant, or summons pertaining to victims of crime.

***Public Health***: We may be required by law to report health related information. These activities may include disclosures to prevent or control disease.

***Complaints***: If you think we have violated your privacy rights described in this notice, or you want to discuss with us about our privacy practices, you can contact: Claudia W. McCoy, Presbyterian Counseling Center, 3713 Richfield Rd., Greensboro, NC, 27410. Phone: 336-288-1484.

Also, you may send a written complaint to the U. S. Department of Health and Human Services, at 1-866-627-7748. If you send a complaint, we will not take any action against you or change our treatment of you in any way.

Revised 1/2018

**Information Sheet 2020**

**Fees for Therapist Services:**

The fee for the **Diagnostic Evaluation** is $150.00. The fee for therapy is $130.00 per 50-minute session.

**Fees for Medical Services:**

Initial Diagnostic Evaluation is $235.00, Medication follow-up visit is $130.00 and family consultations and/or extended medication visits are $175.00. Providers ARE NOT responsible for filling out FMLA or disability forms! Copies of medical records require $35.00 and must be paid **before** they are completed by provider.

**Release of Medical Records:** To release medical records to another provider; release of information must be signed at this practice or the practice you are transferring to. Due to their sensitivity, the release of medical records to client/parent must be accomplished during a **scheduled appointment** with provider on record who will go over medical records before releasing. All records are confidential. Copies of medical records require $35.00.

**Subsidized Sliding Fee Scale:**

A subsidized sliding fee scale is available to anyone unable to pay the therapist fee or those persons who **do not** have insurance benefits. A subsidized sliding fee scale **does not** apply to **medical.** The sliding fee rate is based on the gross family income. You may use current pay stubs and or your income tax forms to verify income. The minimum is $65.00 per session.

**Insurance Services:**

In most cases your health insurance may provide payment for part of your therapy. It is your **responsibility** to verify your **coverage and obtain authorization** from your insurance carrier. Payment of co-pays/deductibles is required at each session. Please notify the front office of **any change** in your **insurance, address, and telephone number.** We participate with most insurance carriers. Fees are subject to change. If you do not provide proper insurance/authorization at time of service **you** are responsible for the bill.

**Payment Information:**

We accept **VISA, DISCOVER, American Express and MASTER CARD, CASH & CHECK** for payments. Payments also are accepted online at **www.presbyteriancounseling.org.** Any checks returned due to insufficient funds (NSF) will result in an additional charge of $25.00. The amount of the check, $25.00 service charge, and any unpaid balance of the account must be paid in cash prior to scheduling the next session.

**Cancellation Policy:**

CANCELLATIONS REQUIRE A 24 HOUR NOTICE IN ADVANCE. You will be charged $50.00 for **therapist** and $50.00 for **medical staff** if cancellations are not received less than 24 hours prior to your appointment or if you do **not show. Insurance does not pay for "NO SHOWS". Continuous cancellation/no shows could result in pre-payment before scheduling appointments or dismissal from practice. You are responsible for no shows and late appointment cancellations at next appointment. Must call front office to cancel appointment not the provider.**

**Medication Refills:**

Please have your pharmacy **Fax** 2 weeks in advance **(336-288-0738)** any medication refills. All written prescriptions require a 2-week notice as well. All prescriptions must be picked up by **4:00 PM** Monday- Thursday and 8:00 - 11:30 Friday. We are closed from 12:00 - 1:00 for lunch Monday thru Thursday.

**Medical Emergencies:**

**For all life threatening emergencies only** after 5:00 call 911 go to your nearest emergency room or call 336-402-8531. For Dr. Brown text or call 336-210-8409 - state name, phone number and date of birth (No authorizations or refills after hours).

Non-Medical Emergencies, you may reach a therapist at 336-402-8690 _____initial_____Date


# Cancellation/No Show Policy

I understand cancellations must be made **24** hours in advance. I will be charged the following in the event I do not give a timely cancellation notice or do not show for my appointment.

| | |
|---|---|
| Medical Staff | $50.00 |
| Therapist Staff | $50.00 |

· Insurance **will not** pay for cancellations or no shows.

Patient: _____ Date: _____

Therapist: _____ Date: _____

Name: _____Date: _____

# Brief Mood Survey*

Instruction: Use an X to indicate how you've been feeling over the past week, including today.
Please answer all items.

**Depression**

| | Not at all | Somewhat | Moderately | A lot | Extremely |
|---|---|---|---|---|---|
| **1. Sad or down in the dumps** | | | | | |
| **2. Discouraged or hopeless** | | | | | |
| **3. Low self-esteem** | | | | | |
| **4. Worthless or inadequate** | | | | | |
| **5. Loss of pleasure or satisfaction in life** | | | | | |

Total items 1 – 5 _____

**Suicidal Urges**

| | Not at all | Somewhat | Moderately | A lot | Extremely |
|---|---|---|---|---|---|
| **1. Do you have any suicidal thoughts?** | | | | | |
| **2. Would you like to end your life?** | | | | | |

Total items 1 – 2 _____

**Anxiety**

| | Not at all | Somewhat | Moderately | A lot | Extremely |
|---|---|---|---|---|---|
| **1. Anxious** | | | | | |
| **2. Frightened** | | | | | |
| **3. Worrying about things** | | | | | |
| **4. Tense or on edge** | | | | | |
| **5. Nervous** | | | | | |

Total items 1 – 5 _____

**Anger**

| | Not at all | Somewhat | Moderately | A lot | Extremely |
|---|---|---|---|---|---|
| **1. Frustrated** | | | | | |
| **2. Annoyed** | | | | | |
| **3. Resentful** | | | | | |
| **4. Angry** | | | | | |
| **5. Irritated** | | | | | |

Total items 1 – 5 _____

**Violent Urges**

| | Not at all | Somewhat | Moderately | A lot | Extremely |
|---|---|---|---|---|---|
| **1. I've had thoughts or fantasies of hurting people** | | | | | |
| **2. I've had the urge to do something harmful or violent** | | | | | |

Total items 1 – 5 _____