



PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

PATIENT INFORMATION

PERSONAL INFORMATION:

PATIENT LAST NAME: _____ FIRST: _____ MI: _____ SEX: ___M___F
SSN: _____ DOB: _____ AGE: _____
STREET ADDRESS: _____ CITY _____ ZIP: _____
PO BOX _____ CITY _____ ZIP _____
HOME PH: _____ ALT #: _____ CELL # _____
MARITAL STATUS: M S W D
STUDENT: Y N NAME OF SCHOOL _____
EMAIL _____

PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY NAME: _____
ID#: _____ GROUP #: _____
NAME OF SUBSCRIBER: _____
RELATIONSHIP TO PATIENT: PARENT SPOUSE OTHER
SUBSCRIBER SOCIAL: _____ DOB: _____

SECONDARY INSURANCE INFORMATION:

INSURANCE COMPANY NAME: _____
ID#: _____ GROUP #: _____
NAME OF SUBSCRIBER: _____
RELATIONSHIP TO PATIENT: PARENT SPOUSE OTHER
SUBSCRIBER SOCIAL: _____ DOB: _____

RESPONSIBLE PARTY:

NAME: _____ SEX: M F
SSN: _____ DOB: _____ AGE: _____
ADDRESS: _____
HOME PHONE: _____ ALT #: _____
MARITAL STATUS: M S D W
RELATIONSHIP TO PATIENT: PARENT/GUARDIAN SELF OTHER

Health Care insurance is a contract between you and your insurance company. It is the patient's responsibility to know their policies and see that we get the proper referrals prior to their visit. All co-payment amounts are due at the time of service, you are responsible for deductibles' and any applicable expenses your insurance does not cover. By signing this agreement you are allowing this office to release any mental health information necessary to process your claims and to also authorize payment of mental health care to Anchor Psychological & Counseling Services, PLLC for services rendered.

SIGNATURE _____ DATE: _____

PRIVACY/CONFIDENTIALITY:

I HAVE READ AND UNDERSTAND THE HIPPA PRIVACY GUIDELINES, THE CLIENT BILL OF RIGHTS, AND THE LIMITS OF CONFIDENTIALITY.

Signature Date

In case of emergency, who should be contacted?
Name _____ Phone _____ Relationship _____

Do you want anyone else to have access to schedule or change your appointments in case you are not able to contact the office yourself? (This does not mean they have access to confidential information, only the right to schedule/cancel appointments.) Please list anyone who you would like to be able to schedule or cancel appointments.

Name: _____ Relationship _____ Phone#: _____
Name: _____ Relationship _____ Phone#: _____

NO SHOW/CANCELLATION FEE:

I UNDERSTAND THAT IF I CANNOT KEEP AN APPOINTMENT, I MUST CANCEL TWENTY-FOUR (24) HOURS PRIOR TO THE APPOINTMENT OR I WILL BE CHARGED A "NO SHOW" FEE OF FIFTY DOLLARS (\$50.00)

Signature Date

CONSENT TO TREAT AGREEMENT:

*******MUST BE SIGNED TO RECEIVE TREATMENT*******

BY MY SIGNATURE HEREIN, I AFFIRM THAT I AM THE CLIENT OR PARENT/LEGAL GUARDIAN OF THE CLIENT AND I HEREBY ACKNOWLEDGE THAT I AUTHORIZE AND GIVE PERMISSION TO THE STAFF OF ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES, PLLC, TO RENDER TREATMENT AND/OR SERVICES TO MYSELF/ABOVE NAMED MINOR, AND I HEREBY ACKNOWLEDGE THAT STAFF IS RESPONSIBLE FOR TREATMENT AND/OR SERVICES RENDERED IN THE COURSE OF TREATMENT (THERAPEUTIC TIME IN FACILITY) AND CANNOT BE HELD RESPONSIBLE FOR MY BEHAVIOR/BEHAVIOR OF MINOR CHILD OUTSIDE OF THE CONTEXT OF THE THERAPEUTIC TREATMENT SESSION.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COPAYMENTS OR DEDUCTIBLES AT THE TIME OF SERVICE. ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES RESERVES THE RIGHT TO USE A COLLECTIONS AGENCY IF ACCOUNTS ARE DELINQUENT MORE THAN 60 DAYS WITHOUT THE RESPONSIBLE PARTY ESTABLISHING AND CARRYING THROUGH ON A PAYMENT PLAN. I UNDERSTAND THAT THE USE OF A COLLECTIONS AGENCY MAY MEAN THAT CERTAIN INFORMATION WILL BE RELEASED TO THE COLLECTIONS AGENCY IN ORDER FOR THEM TO PURSUE THE BALANCE.

FEES FOR SERVICE: PSYCHOLOGICAL EVALUATION/INTAKE: \$225 PHD/\$175 MA, INDIVIDUAL THERAPY-\$135 PHD/\$115 MA, FAMILY THERAPY WITH CLIENT \$155 PHD/135 MA, FAMILY THERAPY WITHOUT CLIENT-135/PHD/\$115 MA, PSYCHOLOGICAL TESTING \$150/UNIT PHD/\$125/UNIT MA.

Signature Date

Signature Date

ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES, PLLC
16581 US HIGHWAY 17 SUITE 600
HAMPSTEAD, NC 28443

PATIENT/CLIENT BILL OF RIGHTS, RESPONSIBILITIES AND
LIMITS OF CONFIDENTIALITY

Anchor Psychological & Counseling services has a written policy identifying their commitment to delivery of client services in **a manner that respects the individual's rights and clearly states the patient's responsibilities.**

RIGHTS

1. Clients have a right to receive information in a clear and concise manner stating the services provided, the practitioners rendering services and knowledge of the treatment plan and options available to them.
2. Clients have a right to expect treatment being rendered with respect, recognition of the dignity and a right to privacy.
3. Clients have a right to participate with the practitioners in determining the most appropriate treatment plan and services, regarding their healthcare.
4. Clients have a right to candid discussions and explanations in decisions related to their treatment and selection/rejection of the most appropriate options, regardless of the cost or benefit of coverage.
5. Clients have a right to voice complaints or request appeals about the services or personnel delivering the services.

RESPONSIBILITIES

6. Clients have a responsibility to provide, to the extent possible, information needed in order **to deliver care with full knowledge of the client's history, current status and other relevant details.**
7. Clients have a responsibility to comply with the treatment plan and instructions for the care they have agreed to with their healthcare providers.
8. Clients have a responsibility to understand their allowances, requirements and limitations of their selected health carriers.
9. Clients are responsible to provide accurate and current information to the practice representative and healthcare providers to permit timely and just coverage for services rendered.

LIMITS OF CONFIDENTIALITY

1. You direct the clinician to tell someone else.
2. The clinician determines that the patient is a danger to themselves or others.
3. The clinician receives information regarding child/elder abuse or neglect.
4. The clinician is ordered by a court to disclose information.
5. If required for insurance billing purposes.

ANCHOR



PSYCHOLOGICAL & COUNSELING SERVICES, PLLC
PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

REASON FOR VISIT: _____

HAVE YOU SOUGHT TREATMENT FOR THIS PROBLEM BEFORE? YES/NO
IF SO, WHEN? _____ WHERE? _____

WHO REFERRED YOU TO THIS CLINIC? _____

HOW DID YOU HEAR ABOUT THIS PRACTICE? (CIRCLE ONE)
ANCHOR WEBSITE FRIEND _____ PRIMARY CARE DOCTOR _____
PREVIOUS CLIENT OF ANCHOR _____ PHONE BOOK CHAMBER
PSYCHOLOGY TODAY CAPE FEAR PSYCH ASSOCIATION
PSYCHIATRIST _____ OTHER CLINICIAN _____

HAVE YOU SOUGHT TREATMENT FOR ANY MENTAL HEALTH/EMOTIONAL
PROBLEMS BEFORE? _____ IF SO, PLEASE EXPLAIN. _____

PLEASE LIST AND DESCRIBE ANY SIGNIFICANT MEDICAL HISTORY (ILLNESSES,
DISEASES, SURGERIES, ALLERGIES, ETC.) _____

PLEASE LIST ANY FAMILY HISTORY OF MENTAL DISORDERS OR MEDICAL
CONDITIONS (LIST CONDITION AND HOW RELATED) _____

PLEASE LIST EVERYONE WHO LIVES IN YOUR HOME, THEIR AGES, AND
SCHOOL/EMPLOYMENT. _____

WHO IS YOUR PRIMARY CARE DOCTOR/CLINIC? _____

ADDITIONAL RELEVANT INFORMATION: _____

Anchor Psychological & Counseling Services, PLLC

Notice of Clinic's Policies and Practices to Protect the Privacy of Your Health Information

HIPPA GUIDELINES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Anchor may use or disclose your Protected Health Information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
 - *Treatment* is when Anchor provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when Anchor consults with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when Anchor obtains reimbursement for your healthcare. Examples of payment are when Anchor discloses your PHI to your health insurer to obtain reimbursement for care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of Anchor. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within Anchor, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- “Disclosure” applies to activities outside Anchor, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Anchor may use or disclose PHI for purposes of outside treatment, payment and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Anchor is asked for information for purposes outside of treatment, payment, and health care operations, Anchor will obtain an authorization from you before releasing this information. Anchor will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes your therapist has made about your conversations during a private, group, joint or family counseling session. By law, these notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent (1) that Anchor has relied on that authorization (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. Use and Disclosure with Neither Consent nor Authorization

Anchor may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If you give Anchor information which leads your therapist to suspect child abuse, neglect, or death due to maltreatment, Anchor must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, Anchor must do so.
- **Adult and Domestic Abuse:** If information you give, gives your therapist reasonable cause to believe that a disabled adult is in need of protective services, Anchor must report this to the Director of Social Services.
- **Health Oversight:** Your therapist's NC professional review board has the power, when necessary, to subpoena records should he be the focus of an inquiry.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, and a request is made for information about professional services Anchor has provided to you and/or the records thereof, such information is privileged under state law, and may not be released without your written authorization or a court order. This privilege does not apply when your being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** Anchor may disclose your confidential information to protect you or others from a serious threat of harm by you.
- **Worker's Compensation:** If you file a worker's compensation claim, Anchor is required by law to provide your mental health information relevant to the claim to your employer and the NC Industrial Commission.

IV. Patient Rights and Therapist's Duties

Patient Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of PHI about you. However, Anchor is 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 PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at Anchor. Upon your request, Anchor will send your bills to another address).
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in Anchor mental and billing records used to make decisions about you for as long as the PHI is maintained in the record. Anchor may deny access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, Anchor will discuss with you the details of the request and denial process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Anchor may deny your request. On your request, Anchor 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 PHI for which you neither provided consent nor authorization (as described in Section III of this Notice). On your request, Anchor will discuss with you the details of the accounting process.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice form from Anchor upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- Anchor is required by law to maintain privacy of PHI and to provide you with a notice of our legal duties and practices with respect to PHI.
- Anchor reserves the right to change the privacy policies and practices described in this notice. Unless Anchor notifies you of such changes, the clinic is required to abide by the terms currently in effect.
- If Anchor revises its policies and procedures, notice will be posted in the lobby.

V. Complaints

If you are concerned that Anchor has violated your privacy rights, or if you disagree with a decision Anchor has made about access to your records, you may contact Mary M. Godin, MA, LPA, LPC.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice is effective August 1, 2007

Anchor reserves the right to change the terms of this notice and to make the new notice provision effective for all PHI that Anchor maintains. Anchor will post notice of any revision to this notice in the clinic lobby and will provide you with a copy upon request.



AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

It is important for your doctor to have all of your medical information to ensure that you receive the best care possible. The purpose of sending the health information to your doctor is to assist in identifying any follow-up medical care that may be needed.

Please allow us to send your health information to your doctor by signing the release of information below. We will only send information that pertains to your care.

Client Name: _____ DOB: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Anchor Psychological & Counseling Services, PLLC to release my health information to:

Dr. _____ () Primary Care Doctor () Psychiatrist

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

INFORMATION TO WHICH THIS AUTHORIZATION APPLIES:

- () Full Clinical Information Record with Substance Abuse
- () Full Clinical Health Information Record Excluding Substance Abuse
- () Psychological Evaluation
- () Verbal Communication
- () Other _____

NOTICE OF RIGHTS AND OTHER INFORMATION

Complete your acknowledgement that You understand that:

- You have the right to review the information that is being used or disclosed
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws
- You have a right to revoke this authorization at any time
- You have a right to receive a copy of this signed authorization.

Permission/authorization to release this information expires one year from the date below.

Patient Signature: _____ Date: _____ Time: _____

Signature Guardian/Parent/Authorized Representative: _____

I decline the release of any of my personal medical record to my Primary Care Doctor.

Name

Signature

Date



ACKNOWLEDGEMENT OF GUARDIAN/CUSTODIAN

I, (print name) _____, certify that I am the legal guardian/custodian of (print name): _____.

Signature

Date

Witness

Date