ANCHOR
PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

PATIENT INFORMATION

LEGAL NAME: _____ **SEX**: M____F____
PREFERED NAME:_____
PREFFERED PRONOUNS_____

DOB:_____**AGE**:_____ **SSN**: _____

PHYSICAL ADDRESS: **MAILING ADDRESS**:

_____ _____
_____ _____
_____ _____

Phone Numbers:
Home #_____
Work #:_____
Mobile #:_____
Email Address:_____(to be used for patient portal set-up)

Please circle your appointment reminder preference: PHONE TEXT EMAIL

MARITAL STATUS: M S W D **RACE**:_____

STUDENT: Y N **NAME OF SCHOOL**:_____

EMPLOYER NAME & ADDRESS:
_____
_____
_____

Emergency Contact:_____**Phone**:_____ **Relationship**_____

Do you want anyone to be able to schedule or cancel appointments for you?
(circle one) Yes No

Name:_____ Phone #:_____Relationship:_____

RESPONSIBLE PARTY:

[ ] Please check here if the patient is the responsible party

For Children or Clients with Guardians, please specify information on both parents and indicate who is responsible for payment. (Note: Ultimately, the person who signs the paperwork is responsible if the parties do not agree unless a court order is shown).

PARENT/GUARDIAN (1):
NAME: _____SEX: M F
SSN: _____DOB:_____AGE:_____
ADDRESS: _____
_____
Phone: (H)_____(M)_____(W)_____
Email Address:_____
MARITAL STATUS: M S D W
RELATIONSHIP TO PATIENT (CIRCLE ONE): PARENT GUARDIAN
IS THIS PARENT/GUARDIAN RESPONSIBLE FOR PAYMENT? Y N (Circle one)

PARENT/GUARDIAN (2):
NAME: _____SEX: M F
SSN: _____DOB:_____AGE:_____
ADDRESS: _____
_____
Phone: (H)_____(M)_____(W)_____
Email Address:_____
MARITAL STATUS: M S D W
RELATIONSHIP TO PATIENT (CIRCLE ONE): PARENT GUARDIAN
IS THIS PARENT/GUARDIAN RESPONSIBLE FOR PAYMENT? Y N (Circle one)

Please Indicate any specific custody arrangements or guardian information.

_____
_____

INSURANCE

PRIMARY INSURANCE INFORMATION:
INSURANCE COMPANY NAME: _____
ID#:_____GROUP #:_____
NAME OF SUBSCRIBER: _____
RELATIONSHIP TO PATIENT: SELF PARENT SPOUSE OTHER
SUBSCRIBER SOCIAL: _____DOB:_____

SECONDARY INSURANCE INFORMATION:
INSURANCE COMPANY NAME: _____
ID#:_____GROUP #:_____
NAME OF SUBSCRIBER: _____
RELATIONSHIP TO PATIENT: SELF PARENT SPOUSE
SUBSCRIBER SOCIAL: _____DOB:_____

ALL CLIENTS: **ASSIGNMENT OF INSURANCE BENEFITS**. I hereby assign all medical and/or therapy benefits, to include major medical benefits to which I am entitled, Private insurance, Tricare, Medicare, and any other health plans to Anchor Psychological & Counseling Services, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim and secure payment for services rendered. If "other health insurance" is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accepts the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, co-Insurance and any non-covered services. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. Please be advised that the contract with health insurance companies requires that Anchor provide it with information relevant to the services that are provided to you. Anchor is required to provide a clinical diagnosis. Sometimes Anchor is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this Agreement, you agree that I can provide requested information to your carrier if deemed necessary.

Signature:_____Date:_____

If you have a supplemental policy and is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized **MEDIGAP** benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the Benefits payable for related services.
SIGNATURE AS IT APPEARS ON MEDIGAP CARD: _____DATE:_____

PATIENT QUESTIONNAIRE

REASON FOR VISIT:

CURRENT ISSUES (Check all that apply to you)

_____ Depression	_____ Body Image	_____ Military Related Problems
_____ Stress	_____ Eating Disorder/Eating Issues	_____ Reintegration
_____ Anxiety	_____ Drug/Alcohol Abuse	_____ Flashbacks
_____ Attention Problems	_____ Physical Abuse	_____ Nightmares
_____ Self Confidence/Self Esteem	_____ Sexual Identity Issues	_____ Sleep Problems
_____ Anger Management	_____ Racial/Cultural Issues	_____ Legal Problems
_____ Sexual Abuse/Molestation	_____ Physical Health	_____ Romantic Relationships
_____ Sexual Assault	_____ Decision Making	_____ Family Relationships
_____ Hyperactivity	_____ Financial Problems	_____ Divorce/Separation
_____ Impulsivity	_____ Delusions	_____ Mania
_____ Grief/Loss	_____ Hallucinations	_____ Homicidal Feelings
_____ Pregnancy (Past, present)	_____ Suicidal Feelings	_____ Fears/Phobias
_____ Learning Disability	_____ Loneliness Isolation	_____ Neglect
_____ Academic		

ADDITIONAL CLARIFICATION FOR VISIT:_____
_____

WHO IS YOUR PRIMARY CARE DOCTOR/CLINIC?_____

PLEASE LIST ALL OF MEDICATIONS WITH DOSAGES, INCLUDING SUPPLIMENTS:

_____

_____

_____

_____

PLEASE LIST ANY ALLERGIES: _____

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

PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

Office Procedures & Financial Policy

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing that you have read the Office Procedures & Financial Policy, you are agreeing to be bound by these terms.

APPOINTMENTS

MISSED APPOINTMENTS: In fairness to other patients and the Therapist, **we require at least 24 hours notice and one business day to cancel an appointment.** (i.e., Appointments scheduled for Monday must be canceled no later than Friday). You may be charged $50.00 for each appointment that was missed or not canceled with 24 hour notice. Missing more than two appointments without providing 24 hours notice is grounds for discharge from the practice. Please be advised that reminder calls are a courtesy, and you will be billed for late cancellations and no shows regardless of whether or not you received the reminder message.

INSURANCE

FOR PATIENTS WITH MEDICARE: We will bill Medicare on your behalf. As a courtesy, we will also bill secondary insurance carriers on your behalf. You are responsible for all co-insurance payments.

FOR PATIENTS WITH INSURANCE: All co-payments and deductibles are due at the time of services. We will bill insurance carriers on your behalf if we have a current contract with the carrier. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable from you. Our office will always strive to help you obtain the maximum possible coverage. It is, however, the patient's ultimate responsibility to determine the extent of coverage allowed by the insurance company.

In addition, preauthorization of a procedure is not a guarantee for payment. Any procedure may be considered not covered under the terms of your agreement with your insurance company. Your insurance carrier will make a determination of payment once the claim is received and reviewed. If after the claim is reviewed and it is determined by your insurance company that the procedure is **not** covered you will be financially responsible to Anchor Psychological & counseling Services, PLLC for the charges and will be billed for those services not covered by your insurance company.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.

FINANCIAL

BASIC POLICY: Payment is due in full at the time service is provided in our office.

RETURNED CHECKS: There will be a fee of $35.00 charged by this office for each check returned to us by your bank.

OUTSTANDING BALANCES: You are responsible for paying any balances due on your account. Once we received the Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account has an unpaid balance, ongoing services may be immediately postponed until full remittance is received.

If you are unable to pay your balance in full, a signed payment plan agreement will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuing services. If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services at Anchor Psychological, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with the Office Manager.

COLLECTION AGENCY COSTS: In the event that your account is forwarded to a collection agency, you agree to pay an additional fee equal up to 33% of the balance forwarded to the collection agency for balances under $75 and 40% for balances over $75 and any additional attorney fees or court costs.

ADDITIONAL SERVICES

In some circumstances, depending on the time involved and the nature of task, you may be charged for additional services such as extended sessions, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment.

Phone Calls: Typically there is no charge for phone calls. However, phone calls that are extended and/or constitute therapy will be billed at the rate of $20/ 15 minutes directly to the client because insurance does not cover this service.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes insurance does not reimburse for testing. In this event, you will be responsible for uncovered testing at the self pay rate. Testing fees will be determined by the type and length of testing.

Collateral Appointments: (Appointments about a client without the client present, i.e., parents meet with therapist without child). Some insurance companies do not reimburse for appointments when the client is not present. This could result in the client being billed at the self pay rate.

RIGHTS & CONSENT TO TREATMENT

- You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- You have the right to be treated in accordance with professional and ethical standards of conduct.
- You have the right to confidentiality. We will not disclose any information outside of Anchor Psychological without your written consent. Clinical records will be maintained in a secure, locked environment. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order. The state law also allows for exchange of clinical information with other medical professionals to assist with coordination of care to provide optimal care.
- You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- I understand that sessions run for 45 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- I understand that there is no guarantee that any particular outcome will result from treatment.
- I understand and give my consent for the Anchor Psychological clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians at Anchor Psychological are Mary Godin, MA, LPA, LPC, LCSW, Kim Johnson, MA, LMFT, Kimberly Giddo, M.Ed., Ed.S, LPC, NCC, LCSW-C, Gabriele Jones PhD Heather Thigpen, MA, LCMHC, Amee Little, MSW, LCSW, LCASA, Emily Carr, MSW, LCSW, Elizabeth Wisker, MSW, LCSW, Andrea Gillespie, MA, LCMHC, LCAS, Erin Sweeney, MSW, LCSW-A, Jessica Cramer, MSW, LCSW-A, Maggie Vester, MSW, LCSW-A and Jennifer Haskins, MSW,LCSW-A.
- I understand that my therapist may consult and share clinical information with their supervisor and/or clinical board in order to provide legal and ethical treatment. They may also do so to meet the requirements set forth for their licensure or certification.

PRIVACY/CONFIDENTIALITY:

I HAVE READ, UNDERSTAND, AND AGREE TO THE HIPPA PRIVACY GUIDELINES, THE CLIENT BILL OF RIGHTS, THE OFFICE PROCEDURES AND FINANCIAL POLICY, THE RIGHTS AND CONSENT TO TREAT, AND THE LIMITS OF CONFIDENTIALITY. I HAVE CONSENTED TO ANCHOR PSYCHOLOGICAL BILLING MY INSURANCE COMPANY AND UNDERSTAND THAT THE RESPONSIBLE PARTY IS RESPONSIBLE FOR ANYTHING NOT COVERED UNDER INSURANCE.

_____ _____

Name of Client Name of Responsible Party (if under age of 18)

_____ _____

Signature of Client/Client Representative Date

INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES

- -There are potential benefits and risks of videoconferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- -Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- -We agree to use the video-conferencing platform selected for our virtual sessions, and the Clinician will explain how to use it.
- -You need to use a webcam or smartphone during the session.
- -It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- -It is important to use a secure internet connection rather than public/free Wi-Fi.
- -It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the clinician in advance by phone or email.
- -We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- -We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis.
- -If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- -You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- -As your Clinician, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.
- Doxy.me will be used as our platform. This is HIPAA compliant and you will assess it through a link posted on our website.

___INITIAL IF YOU DECLINE TELEHEALTH SERVICES

OR

___INITIAL IF YOU UNDERSTAND AND AGREE TO TELEHEALTH AND THE ABOVE POLICIES

INFORMED CONSENT FOR IN PERSON SERVICES

This document contains important information about our decision (yours and mine) to resume in-person services. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

- We have agreed to meet in person for some or all future sessions. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.
- If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, if it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

If You or I Are Sick

- You understand that I am committed to keeping you, me, [my staff] and all our families safe from any contagious ailment. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Patient/Client Name Date

_____ _____

Signature of Client/Responsible Party

Date

Anchor Psychological & Counseling Services, PLLC

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Client Name:_____ DOB:_____ DATE:_____

PURPOSE OF RELEASE:

Further mental health care Payment of insurance claim Legal investigation Coordination of Care Applying for insurance Disability determination At the request of the individual Other (specify): _____

MUTUAL EXCHANGE OF INFORMATION

Anchor Psychological and Counseling Services, PLLC		Mr/Ms/Dr. _____
16581 Highway 17, Suite 600		Address:_____
Hampstead, NC 28443	**AND**	City:_____ State:_____ Zip:_____
Phone: (910) 270-9995 Fax: (910) 270-9905		Phone:_____ Fax:_____

INITIAL appropriate information to be released (Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.):

_____My Entire Mental Health Record including Substance Abuse
_____Verbal Communication
_____Only Those Portions pertaining to:_____
(Specific Provider name and/or dates of treatment)
_____Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
_____I Decline

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.

Notice: *This information has been disclosed to you from records protected by the Federal Confidentiality Rules (42 CFR, Part 2). The Federal rules prohibit your from making any further disclosure of this information unless, further disclosure is expressly authorization for the release of the medical or other information is NOT sufficient for this purpose. The Federal Rules Restrict any use of the information of criminally investigates or prosecute any alcohol or drug abuse patient.*

Date of Authorization: ___/___/_____ Authorization to expire on ___/___/_____
Note: Authorizations are valid for a maximum of one year.

Patient Signature: _____ **Date**:_____ **Time**:_____
Signature Guardian/Parent/Authorized Representative: _____
If signed by a personal representative:
(**A**) Print your name: _____
(**B**) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: Minor Incompetent Disabled Deceased
Legal authority: Parent Legal Guardian Representative of Deceased

Recurring Credit Card Payment Authorization Form

I _____ understand and authorize Anchor Psychological and Counseling Services to charge the credit card on file for the amount stated by my insurance policy or payment agreement and that payment is due at the time services are rendered. I also understand that this card will also be charged a fee of up to $50 for an appointment that is Cancelled without adequate notice (less than 24hrs) or is a No call No Show. This fee is at the discretion of my provider and is outlined in the Financial Policy of the Intake Forms.

Name on Card: _____

Billing Address:_____

City, State, Zip _____

Phone Number: _____

Email for Receipt:_____

Client name: _____

Client/ Guardian SIGNATURE _____

ANCHOR
PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

Statement about Custody/Divorce for Children

Anchor Psychological strives to assist clients in improving their mental health and reducing symptoms. In juvenile cases where a divorce is involved, we will ask for a copy of the custody paperwork to make sure that we are following the rules set out for consent to care. It is our preference to have consent from both parents. We are here to help your children, NOT to testify and we will only treat children where parents agree to not subpoena the therapist or the records for a custody case as this puts us in a dual relationship and causes ethical concerns and can hurt the therapeutic relationship.

Please attach a copy of the custody agreement. If one is not available, we will require both parents to consent to treatment.

Please provide the following information:

Parent (Mother)

Name _____

Address _____

Phone Number _____

Custody Arrangement, explain_____

Is the mother responsible for all or some of the bill (explain)?_____

Parent (Father)

Name _____

Address_____

Phone Number _____

Custody Arrangement, explain_____

Is the father responsible for all or some of the bill (explain)?_____

By signing this paper, we agree to enter into therapy to help our child reduce symptoms and we will not request information that would be used in court nor will we subpoena the therapist to testify.

_____ _____

Mother's Signature Date

_____ _____

Father's Signature Date