Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

A Peace of Mind Counseling, PLLC
2504 Raeford Rd, Suite 108, Fayetteville, NC 28305
Phone (910)423-9900 Fax (910)423-0537

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems	**Duration** (months)	**Additional information**:

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	circumstantial symptoms	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) _____	[ ]	[ ]	[ ]	[ ]

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] [ ] Prior outpatient psychotherapy?
No Yes If yes, on _____occasions. Longest treatment by _____ for ____ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

[ ] [ ] Has any family member had outpatient psychotherapy? If yes, who/why (list all):_____
No Yes _____

[ ] [ ] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?
No Yes If yes, on _____occasions. Longest treatment at _____ from ___/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

[ ] [ ] Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes,
No Yes who/why (list all):_____

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

[ ] [ ] Prior or current psychotropic medication usage? (continue on back or additional sheet as needed) If yes:

No	Yes	Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

[ ] [ ] Has any family member used psychotropic medications? If yes, who/what/why (list all):_____

No Yes _____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

_____

Parents' current marital status:

[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ___

Describe parents:

	Father	**Mother**
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _____ **Circumstances:** _____

_____

_____

Special circumstances in childhood:_____

_____

_____

IMMEDIATE FAMILY

Marital status:

[ ] single, never married
[ ] engaged ____ months
[ ] married for ____ years
[ ] divorced for ___ years
[ ] separated for ___ years
[ ] divorce in process ____ months
[ ] live-in for ____ years
[ ] ___ prior marriages (self)
[ ] ___ prior marriages (partner)

Intimate relationship:

[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient

List children <u>not</u> living in same household as patient:

Frequency of visitation of above: _____

Describe any past or current significant issues in <u>intimate</u> relationships: _____

_____

_____

_____

Describe any past or current significant issues in other <u>immediate family</u> relationships: _____

_____

_____

_____

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

_____

List name of primary care physician:

Is there a history of any of the following in the family:

[ ] tuberculosis [ ] heart disease
[ ] birth defects [ ] high blood pressure

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

Name _____ Phone _____

List name of psychiatrist: (if any):
Name _____ Phone _____

List any medications currently being taken (give dosage & reason):
_____
_____
_____

List any known allergies: _____

List any abnormal lab test results:
Date _____ Result _____
Date _____ Result _____

[ ] emotional problems [ ] alcoholism
[ ] behavior problems [ ] drug abuse
[ ] thyroid problems [ ] diabetes
[ ] cancer [ ] Alzheimer's disease/dementia
[ ] mental retardation [ ] stroke
[ ] other chronic or serious health problems _____
_____

Describe any serious hospitalization or accidents:
Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date: _____ Age _____ Reason _____

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used:

(complete all that apply)	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol					
[ ] amphetamines/speed					
[ ] barbiturates/owners					
[ ] caffeine					
[ ] cocaine					
[ ] crack cocaine					
[ ] hallucinogens (e.g., LSD)					
[ ] inhalants (e.g., glue, gas)					
[ ] marijuana or hashish					
[ ] nicotine/cigarettes					
[ ] PCP					
[ ] prescription_____					
[ ] other_____					

Treatment history:

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)
[ ] stopped on own (age[s]_____)
[ ] other (age[s]_____
describe:_____

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other _____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:

[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
_____
birth weight ____lbs ___oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:

[ ] chickenpox (age _____) [ ] lead poising (age _____)
[ ] German measles (age _____) [ ] mumps (age _____)
[ ] red measles (age _____) [ ] diphtheria (age _____)
[ ] rheumatic fever (age _____) [ ] poliomyelitis (age _____)
[ ] whooping cough (age _____) [ ] pneumonia (age _____)
[ ] scarlet fever (age _____) [ ] tuberculosis (age _____)
[ ] autism [ ] mental retardation
[ ] ear infections [ ] asthma
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems _____
_____

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

Delayed developmental milestones (check only those milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other _____
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):

[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things
[ ] other _____

Social interaction (check all that apply):

[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other _____

Intellectual / academic functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation

Current or highest education level _____

Describe any other developmental problems or issues: _____

_____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:

[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Employment:

[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] unstable work history
[ ] disabled: _____

Financial situation:

[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income
[ ] impulsive spending
[ ] relationship conflicts over finances

Social support system:

[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin

Military history:

[ ] never in military
[ ] served in military - no incident
[ ] served in military - **with** incident

_____

Legal history:

[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison _____ time(s)
total time served: _____
describe last legal difficulty: _____
_____

Sexual history:

[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age first sex experience _____
[ ] age first pregnancy/fatherhood ___
[ ] history of promiscuity age ___ to ___
[ ] history of unsafe sex age __ to ___

Additional information: _____

Cultural/spiritual/recreational history:

cultural identity (e.g., ethnicity, religion): _____
_____
describe any cultural issues that contribute to current problem: _____
_____
currently active in community/recreational activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: _____
_____
_____

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

SOURCES OF DATA PROVIDED ABOVE: [ ] Patient self-report for all [ ] A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Family History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Developmental History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Emotional/Psychiatric History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Medical/Substance Use History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Socioeconomic History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

*******Failure to complete this form or leave a deposit will result in delay or prevention of your ability to receive services under your primary insurance benefits. *******

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Phone (910)423-9900 Fax (910)423-0537

CLIENT FINANCIAL RESPONSIBILITY FORM

A Peace of Mind Counseling, PLLC charges clients for services that are not covered by their insurance provider & require clients place a method of payment on file to cover charges not paid by insurance. *In the event that additional services are not utilized or requested, the check or debit card will remain on file and client will NOT BE BILLED.*

Fees that are billed to clients/responsible party that are not covered by insurance companies include the following:
-Co-payments for services -Missed appointments or No Shows – $150.
-Appointments cancelled with less than 24hrs notice that are not emergencies- $150.
-Returned check fee-$50. -Letter writing-$50 minimum
-Any charges, including but not limited to; letter writing, telephone consultations, collateral contacts, & completion of disability documents are considered the client's/responsible party's liability.

Court Cost:
$250.00 testimony with four hour minimum (per client)
Portal to Portal fee $100.00 (per client)
Court costs are to be paid in advance and are non-refundable
These charges are non-refundable unless notified within 3 business days prior to the scheduled court appearance, that physical presence will not be required in court on said date. However, balances will be paid for any and all provided services.

Please attach **check in the amount of $150.00 made out to A Peace of Mind Counseling, PLLC or debit/credit card information below** to cover fees or other charges not paid by insurance or a credit/debit card may be provided. If leaving a credit or debit card, please leave your signature below. Your signature below authorizes A Peace of Mind Counseling, PLLC to charge for fees not payable by insurance to your credit/debit card, or the cashing of your check for the same purpose. In addition, your signature acknowledges that you have read, agreed to, and fully understand the policy explained above. Furthermore, you authorize the verification of funds availability with regard to the checking or credit card account in question.

*****If you are unable to provide either check or credit/debit card, you can leave a $150.00 cash deposit. Unfortunately, services will not be provided without a deposit in one of these forms. If undated check or cash deposit is not used at the time of service completion, the check or cash will be returned if requested and/or shredded.*****
[ ]I will leave a deposit by: (check one) [ ]Undated Check (# _____ & $_____) [ ]Cash ($_____)

_____ _____ _____ _____
Signature of Client/Responsible Party Printed Name Relationship to Client Date

_____
Initial noting reading and understanding of form

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

[ ] I will leave a deposit by: (check one) [ ]Credit Card [ ]Debit Card
Would you like to use this card for co-pay charges, if applicable? [ ]Yes [ ]No
I hereby authorize A Peace of Mind Counseling, PLLC employees or agents thereof, and ProfessionalsCharges.com to charge my credit or debit card for any applicable fees such as deductible, co-payments or no show/late cancellation feeds. Charges will appear on your credit card statements as ProfessionalCharges.com and an invoice will also be available for your records.

Client Name:_____ Name as it appears on the card:_____

Type of card: (check one) [ ]Visa [ ]MasterCard [ ]Discover [ ]Other _____

Expiration Date: _____/_____ Card Number _____- _____ - _____ - _____ CVV Number __ __ __

Card Holder's billing address where credit card statements are sent:

_____
Street City State Zip Code

Card Holder Signature: _____Date:_____

_____
Initial noting reading and understanding of form

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

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INFORMED CONSENT/FINANCIAL AGREEMENT FOR MENTAL HEALH ASSESSMENT and TREATMENT

The goals of therapy are to provide the following:
-information -emotional support
-teach skills -to improve personal effectiveness
-to preserve personal safety/develop problem solving strategies

Although, psychotherapy has been shown to produce significant improvement in emotional well-being; family and personal relationships; & work and school performance; it still must be stated that there are both risk and benefits. The risk include experiencing uncomfortable levels of feelings such as feelings of frustration, loneliness, sadness, &/or guilt. Powerful benefits of psychotherapy include life-changing behaviours and or ways of thinking which forever shape the way one feels in a more proactive and positive manner that is not only more positive and healthy.

Therapy has a natural process to it which includes a beginning (getting acquainted, identifying problems, setting goals), a middle (treatment activities – exploring approaches, developing solutions), and an ending (evaluation of goal attainment, after-care goals, closure activities). We encourage you to see your therapy through all three phases for optimal effectiveness. There are no guarantees of success in therapy when one begins the journey, but it is hoped that if one begins the process in an honest endeavour that one will reap some of those benefits.

The first therapy session is called Intake. This session, and sometimes part of the second session, focuses on identifying your problems, needs, and issues so we can develop goals and discuss possible treatment interventions that will work best for your needs. These interventions could include individual, family, or group sessions with a variety of uses from various clinical approaches from many evidenced based approaches. Not all diagnoses and treatment modalities are included as covered benefits in all health plans. We will work with you to ensure that if you choose to use your insurance benefits, you may do so in the most effective manner. If you are unable to use your benefits, or if you choose not to order to preserve full confidentiality, we will assist you in making payment arrangements so that you may handle payments on an affordable private pay basis.

LENGTH OF THERAPY

Therapy is designed to accomplish goals that you and your therapist develop together. The time it takes to reach your goals varies with your individual needs and circumstances, as well as the energy you put toward goal accomplishment. The method, duration, and frequency of your sessions will be determined by you and your therapist. However, your insurance carrier may choose to only authorize payments for services they deem to be medically necessary. Typically, in the early phases of treatment, individual, couple, and family sessions are conducted once a week or every two weeks. As therapy progresses, the sessions are held less frequently. Therapy sessions are usually 45 minutes in duration.

EMERGENCY PROCEDURES

Your provider may be reached after business hours at the number provided below if you are unable to obtain emergency services through your assigned emergency procedures noted in specific treatment plan. If there is an emergency, please contact 911; go to the nearest emergency room; or contact your local Management Entity (LME) or

mental health emergency contact number. Your signature below indicates that you have received this information and are aware of this protocol.

Laura Lawyer, MSW, LCSW
Cell Phone (704) 796-2565

PAYMENT POLICIES

A Peace of Mind Counseling requires payment in full at the time services are provided unless alternative arrangements are agreed to in advance, in writing, or the client is a member of an HMO, PPO, or other managed care organization. If you are a member of such an organization, you may be responsible for obtaining an authorized number prior to receiving services. If proper initial authorization is not obtained, you will be responsible for the full cost of the services rendered. We must ensure that payments are collected to ensure that we are able to provide services and continue to operate our business.

In addition, we have a legal and contractual obligation with insurance carriers to collect your co-payment at the time we render professional services.

APPOINTMENTS MUST BE CANCELED AT LEAST 24 HOURS IN ADVANCE TO AVOID A CHARGE AND DISRUPTION IN CONTINUATION OF SERVICES

-Your insurance company will not pay for missed appointments
-If individuals cancel and/or no show, A Peace of Mind Counseling, PLLC will bill the fee of $150.00 for the missed appointment time that we are unable to schedule to other potential billable clients. We do not want to do such, but must bill to ensure the financial security of the practice.
-Appointment times are valuable to those who need and want these times, and therefore, those whom are willing to be present for the appointment must have the ability to have these times available to them
-Therefore, if one fails to show up for their appointment (MORE THAN 15 MINUTES LATE); CALL AND CANCEL AT THE LAST MINUTE; ANOTHER APPOINTMENT WILL BE UNABLE TO BE SCHEDULED WITH YOU UNTIL YOUR FEE FOR MISSING THE APOINTMENT HAS BEEN PAID. True emergencies are an exception and you are aware of what a true emergency is, but can contact the office if there are questions. Also, payments must be obtained by the billing or therapy office prior to additional appointments being scheduled or reinstated for client.

Other fees that are as follows:
$50 - returned check fee
$150 prorated fee per hour - disability or court report

If physical presence is required in court, a fee of $250 (per client) per hour with a 4 hour minimum is charged and payable prior to the court date (unless discussed by client and therapist have agreed upon another agreement). These charges are non-refundable unless we are notified within 3 business days prior to the appearance that physical presence will not be required in court. However, preparation of and for court if already conducted will be billed if conducted by that time.

If financial obligations are not met, client account information may be turned over to a collection agency. The information provided will include client's name, address, telephone number, and amount due. You are responsible for informing us of any other health insurance you may possess in addition to your primary carrier and any policy changes that may affect your mental behaviour health benefit. Failure to do so may result in your being liable for payment of services rendered if your insurance company fails to pay due to inadequate coordination of

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

_____

Initial noting reading and understanding of Financial Responsibility Form

Explanation of Services/Fees:
My signature on this page means that I have read and have agreed with the information presented above, and that I have the legal right to make such agreements. I am agreeing to the mental health assessment and to have all mental health treatment reviewed and discussed with me by my therapist. I also state that I have read and understand the Notice of Privacy Practices which is available in the agency and on the agency website.

_____ _____ _____ _____

Signature of Client/Responsible Party Printed Name Relationship to Client Date

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of A Peace of Mind Counseling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Laura Lawyer, MSW, LCSW, Privacy Officer at 2504 Raeford Road, Suite 108, Fayetteville, NC 28305 or contact by telephone at 910-423-9900 or by Fax at 910-423-0537.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

Contact by Telephone/Verbally in Event of Breach of Protected Health Information

I, _____ (Client Name), authorize A Peace of Mind Counseling to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by A Peace of Mind Counseling. Such conversation shall be documented by A Peace of Mind Counseling.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of A Peace of Mind Counseling.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

Client name _____ Client DOB: _____ Client Insurance ID: _____Date_____

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NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice takes effect on May 6, 2010 and remains in effect until replaced.

OUR COMMITMENT REGARDING YOUR MEDICAL INFORMATION:

The privacy of your medical information is very important to us. We are committed to protecting your personal medical information. The identifying information about yourself, and the information related to your past, present or future physical or mental health/condition and health care services is referred to as Protected Health Information ("PHI"). We create a record of the care and services you receive at A Peace of Mind Counseling in order to provide you with quality care and to comply with certain legal and ethical requirements. This notice will tell you about the ways we may use share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL RESPONSIBILITY:

The law requires us to keep your medical information private, provide you with this notice describing our legal duties, private practices, and your rights regarding your medical information; and to follow the terms of the current notice. We have a right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have a right to make any changes and the new terms of our notice effective for all medical information we keep, including information previously created or received before the changes. We will provide you with a copy of the revised Notice of Privacy Practices by providing a copy at your next appointment, sending a copy via mail or email at your request, and having a copy posted in our office waiting room. Our company website may also have links to this document.

HOW MAY WE USE OR DISCLOSE YOUR HEALTH INFORMATION:

For Payment We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities include: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. A bill may be sent to you or a third party payor and the information on the bill may include your medical information. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Treatment Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your

authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Healthcare Operations We may use of disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing , training or teaching , and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various businesses that require it to safeguard the privacy of your PHI.

Required by Law Under the law, we must disclose your PHI to you upon request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purposes of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorizations Following is a list of the categories of uses and disclosures permitted by HIPPA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

-Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment *based on your consent or as necessary to prevent serious harm.* We will share information about your location, general condition, or death. If you are present, we will attempt to get your permission prior. If you are unable or refuse to grant permission, we will give the minimum necessary information according to our professional judgment.

-Victims of Abuse, Neglect, or Domestic Violence. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health, safety, or the health and safety of others.

-Appointment Reminders. We may disclose and use medical information for purposes of reminding you of appointments via phone or through other communication methods.

We furnish you with information about health related benefits and services that may interest you, and to describe or recommend treatment alternatives.

-Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena, court order, administrative order or similar process. (Our office will attempt to gain your written consent or file appropriate motion therapist believes to be in best interest of client.) We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being a participant in a crime or has escaped legal custody. We may share limited information with law enforcement concerning medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share medical information of an inmate or other person in lawful custody of a law enforcement officials or a correctional institution under certain circumstances.

-Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate. We may share information with a funeral director, coroner, organ procurement organization or medical examiner to help them carry out their duties.

-Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practical after the resolution of the emergency.

-Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigators, licensures, disciplinary action, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilizations and quality control.

-Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena, court order, administrative order or similar document for the purposes of identifying a suspect, material witness or missing persons, in connection with the victim of a crime in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises. (Attempt will be made to obtain client's written consent or file appropriate motion to protect the best interest of the client.)

-Specialized Government Functions. We may review request for U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

-Workers Compensation. We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

-Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a governmental agency that is collaborating with the public health authority**.**

-Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

-Disaster Relief. We may share medical information with a public or private organization or person who can legally assist with disaster relief efforts.

-Research. We may use medical information for research purposes in limited circumstances where the research has been approved by a review board and established protocols to ensure the privacy of medical information.

Verbal Permission We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time. However, revoking authorization will not pertain to previously released information prior to the revoking of an authorization.

YOUR RIGHTS REGARDING YOUR PHI:

You have rights regarding your PHI that is maintained about you. To exercise such rights, please submit such request in writing to our Privacy Officer, Laura Lawyer, MSW, LCSW at A Peace of Mind Counseling.

- **Right to Access to Inspect and Copy.** You have a right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PH and will be charged a fee for electronic record transmission on appropriate medium.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that we make on your PHI. We may charge you a reasonable fee if you request an accounting of such.
- **Rights to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations, and the PHI pertinent to a health care item on service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice. You may keep the paper copy given to you at time of intake or request one at any time from your therapist. It is also available in our waiting room as well as postings on our website.
- **Right to Complain.** If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Laura Lawyer, MSW, LCSW at A Peace of Mind Counseling, 2504 Raeford Rd, Suite 108, Fayetteville, NC 28305, 910-423-9900 or with the Secretary of Health and Human Services at 200 Independence Avenue, SW, Washington, DC 20201, 202-619-0257. We will not retaliate or take measures against you due to your having filed a complaint.
- **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI maybe revoked at any time IN WRITING. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. We are required to retain records of your care. Any further billing of visits after

revoking authorizations for uses and disclosures will require client or designated individual, financially responsible for charges for services. This would be necessary due to office being prohibited from disclosure for billing through client's insurance carrier for payment of services.