REGISTRATION FORM

(Please provide insurance card and drivers license to receptionist)

Today's date:	Referred by:

PATIENT INFORMATION

Patient's last name: First: Middle:	Sex: ❑Male ❑ Female	Age:	Patient birth date:

Patient marital status (circle one) Single / Mar / Div / Sep / Wid	Patient Social Security:	Patient Cell: ( )	Home phone: ( )

Street address:	City: State: Zip code:

Patient occupation:	Patient employer:	Employer phone: ( )

EMAIL ADDRESS:

Full name of children in birth order (if applicable):

Others living in home and their relationship to patient:

Personal physician:	Address:	Phone: ( )

Current therapist:	Address:	Phone: ( )

List of all medication's patient is currently taking:

Has patient been hospitalized in past 5 years? If yes, for what reason?

Has patient had previous psychological or psychiatric treatment? Where and when?

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone: ( )

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no:	Birth date: / /	Group no:	Policy no:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Work phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Southlake Counseling. **I understand that I am financially responsible for any amount not covered by insurance**. I also authorize Southlake Counseling or insurance company to release any information concerning my illness and treatments required to process my claims.

Patient/Guardian signature *Date*

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Southlake Counseling and Consulting
Southlake Center for Self-Discovery

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my health care providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information (PHI). I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my health care provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that *Southlake Counseling and Consulting* and *The Southlake Center For Self Discovery* restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that *Southlake Counseling and Consulting* and *The Southlake Center For Self Discovery* are not required to agree to my requested restrictions, but if *Southlake Counseling and Consulting* and *The Southlake Center For Self Discovery* do agree then you are bound to abide by such restrictions.

Patient Name _____Date _____

Signature_____

Relationship to Patient _____

For Office Use Only
We were unable to obtain the patient's written acknowledgement of our ***Notice of*** *Privacy Practices due* to the following reason:

___The patient refused to sign ____Communication barriers

___Emergency situation ___Other: _____

Cancellation Policy

Southlake Counseling and Consulting
Southlake Center for Self Discovery

Last minute cancellations and no shows impact not only you and your therapist, but it does not allow another patient to benefit from the service that could have been made available with enough notice from you.

We request a minimum of a 24 hours notice for cancellations prior to your scheduled session.

The late cancellation fee (total cost of session) will be applied for appointments that are cancelled within 24 hours and missed appointments/no-show fee (total cost of session) will be applied for not keeping scheduled appointments.

Your insurance company will not pay for your late cancellations, missed appointments or no-show.

It is your responsibility to keep up with your appointments. Confirmation calls are a courtesy and are not guaranteed.

By signing below, I am acknowledging that I have read and understand the cancellation policy.

_____ _____

Signature of Patient Date Witness Date

_____

Parent/Guardian Signature Date

Payment Collection

Southlake Counseling and Consulting
Southlake Center for Self -Discovery

Dear Southlake Client:

This letter is to inform you of some changes to payment collection at *Southlake Counseling and Consulting* and *The Southlake Center for Self-Discovery* starting January 1, 2020:

- All deductibles/copays/coinsurance are due at the time of service.
- A card must be put on file to cover any late cancellation/no show fees.
- Any back balances still owed to Southlake will be set up on a payment plan.
- Payment plans will be charged a 1.5% interest rate monthly.
- Please review the payment agreement attached (if there is an outstanding balance on your account), sign and return with first payment due.
- Any balances not paid on time or at time of appointment will be subject to a $35 late fee and 1.5% interest charge.
- Any balances not set up on a payment plan, must be paid in full within 30 days of first statement to avoid outside collections.
- Any check returned to Southlake for non-payment will be subject to a $50 check fee.
- Any credit card on file for payments will be subject to a $35 fee if funds are not available (card declines).
- Any service provided by *Southlake Counseling and Consulting* or *The Southlake Center For Self-Discovery* is non-refundable.

Any questions or concerns, please do not hesitate to call.
Sincerely,

Kimberly Krueger, LCSW
Owner/Director
Office Manger

_____ _____

Signature Date

In Case of an Emergency

Southlake Counseling and Consulting
Southlake Center for Self Discovery

Southlake Counseling and Consulting and *The Southlake Center for Self-Discovery* is not a medical facility. Therefore, we only admit participants that are physically safe. For this reason, we ask that you see a physician for blood work (Biochemical Profile and CBC) and that you consent to the following policy. During treatment, some patients have suicidal, self-harm or homicidal thoughts. These generally pass within hours or days if discussed in sessions. You may call the Center at any time during working hours and leave a message for your primary therapist who will make every effort to call you back before the end of the day. If you have an emergency after hours (5:30 pm- 9:30 am) or on the weekend, you may leave a message with your therapist at 704-896-7776.

Please read the following contract, which is required of all individuals being treated on an outpatient basis at *Southlake Counseling and Consulting* and *The Southlake Center for Self Discovery*:

1. I promise to talk with my individual therapist if I should have any thoughts of harming myself or someone else. I understand that for some individuals, these thoughts may be a natural part of the therapy process and are likely to pass if I talk about them.
2. I understand that the ultimate responsibility for my health and therapy is my own. Therefore, I agree to give my therapist 48 hours to respond to my call. In the interim, I may phone a hotline for support or go to an emergency room if unable to keep myself safe.

I have read and understand the emergency policies and promise to abide by them.

_____ _____

Signature of Patient Date Witness Date

_____ _____

Parent/Guardian Signature Date Witness Date

Southlake Counseling/Southlake Center for Self-Discovery
Notice of Billing Policies & Procedures

Thank you for choosing Southlake Counseling! We are committed to providing you the best care possible all while keeping our services affordable for all of our clients. We will strive to optimize your insurance benefits as much as possible.

Health insurance is a contract between you, your employer and your health insurance company. Each policy has different rules regarding which services are allowed, deductible amounts, how you are charged, where lab work is sent, etc. You are responsible for knowing the terms of your health contract benefits. We need all of the information on the attached demographics sheet as well as a copy of your insurance card (s). Be sure to give us your primary AND secondary cards if applicable. If the time frame of submission of a claim lapses due to incorrect information, you are responsible for those fees.

Prior approval is required for most mental health treatment. You are responsible for getting the initial authorization number. If you have it, and have not already called it in to us, please provide it to the receptionist. If not, we will ask that you use our phone to get that number PRIOR to being seen. Additionally, some polices require that your Primary Care Physician refer you to us. We must have such referral in hand before we can proceed. YOUR FAILURE TO OBTAIN THE PROPER REFERRAL OR INITIAL AUTHORIZATION WILL MAKE YOU FULLY RESPONSIBLE FOR OUR FEES. You may be limited by your policy in the number of mental health visits per year allowed or you may have a dollar limit.

At the time of service, deductible, copayments and/or your percentage of fees are payable. Any balance due after your insurance company pays or denies your claim is payable BY YOU.

BILLING POLICIES AND PROCEDURES

The credit card on file is used to bill for account balances, and any late cancelation or no-show fees. This card will not be authorized without your permission unless there is a balance on your account due to failure of payment.

Please be sure to contact your insurance company to confirm your mental health and/or substance abuse benefits or that that reimbursement is an option.

Should your insurance provider reject your claims, if there is a deductible that needs to be met, *or* if mental health services are provided and not covered by your insurance company for any reason, you are responsible for the full fee as detailed above and on your service agreement.

Your credit card on file will be charged immediately for any missed payments or when payments are not covered by the insurance company. Your credit card will also immediately be charged for any late cancelation and no-show fees. We will call all clients to inform them what we are charging the Card on File for prior to running the card.

The no show fee, as of January 1, 2020, is the cost of the session.

I agree to update my credit card on file as necessary. If the card on file is declined, or if there is a charge back fee, there will be a $35 decline penalty added to your balance.

If we have to use an outside agency to collect the balance on your account or obtain current address, insurance information, etc., an administrative fee will be billed to your account.

1. Telephone calls to clinicians may be subject to a $35 minimum charge.
2. Pharmacy call-ins may be subject to a $10 charge, if authorized by your psychiatrist.
3. Processing time/paperwork with your insurance to obtain non-formulary medication authorization is subject up to a $35 charge.
4. Form letters, reports, etc. are subject to a $25 administrative charge.
5. Missed appointments not cancelled 24 hours in advance will be charged to you AT FULL FEE even if you did not receive a reminder call.
6. Payment is due at the time of service, unpaid fees/co-payments will be assessed a $3.00 surcharge.
7. Any involvement in court procedures, depositions, or testimonies are billed at $250.00 an hour, to include travel and documentation preparation time. A $500 retainer fee and a Card on File form will be required at the time of subpoena.
8. Any service provided by *Southlake Counseling and Consulting* or *Southlake Center for Self-Discovery* is non-refundable
9. Receipts will be provided free of charge one time for each visit. Any receipts requested more than once will be provided at the cost $0.20 per page.

Please remember YOU, not your doctor, are the policyholder. If your insurance fails to pay on a timely basis, (within 60 days), we will send you a statement of account notifying you that your claim is unpaid, at which time you/your employer must assist in pursuing your benefits.

I _____ have read Southlake Counseling and Consulting's billing policy and I acknowledge that my card on file will be charged for any balances that may occur from my failure to pay my expect co-pay or any balance that is left from my insurance company. I agree to the terms and conditions that Southlake Counseling has set.

Clients Signature/Date:_____

Card on File

Please select your billing preference below.

Pay in Session Charge Card on File

CREDIT CARD INFORMATION

Credit card on file is used to bill for copayments, account balances, and any late cancelation or no-show fees.

Name on Card: _____

Type of Card: _____ Card Number: _____

Expiration Date: _____Security Number (On back of card): _____

Zip Code: _____ Client Initials: _____

HSA/FSA CARD INFORMATION

The HSA/FSA Card on file will always be billed first. Only if the card is declined will the credit card below be used.

Name on Card: _____

Type of Card: _____ Card Number: _____

Expiration Date: _____Security Number (On back of card): _____

Zip Code: _____ Client Initials: _____

AGREEMENT IS UNDERSTOOD, AGREED, & APPROVED

I have carefully reviewed this contract and agree to and accept all of its terms and conditions. I understand that this is a legal document with legal consequences which could be enforceable in a court of law.

By signing this Agreement, I agree to be bound to the terms and conditions of this contract. I have carefully reviewed this entire Agreement. I agree to and accept all of its terms and conditions. I understand that this is a legally binding agreement, and I am executing this Agreement as of the Effective Date below.

Client Name: _____

Client Signature: _____ Date: _____

Clinician Signature: _____Date: _____

Notice of Privacy Practices

Under the Health Information Portability & Accountability Act

H.I.P.A.A.

The effective date of this Notice of Privacy Practices is August 15, 2003

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

As a part of our services, we maintain personal information about you and your health. State and federal law protects such information by limiting its uses and disclosures. "Protected health information" (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to you past, present, or future physical or mental health or condition, the provision of health care services, or the past, present, or future payment for the provision of health care. The confidentiality of alcohol and drug abuse patient records is also specifically subject to additional restrictions under other state and federal law. We are required to comply with these additional restrictions.

Your Rights Regarding Your PHI: The following are your rights regarding PHI that we maintain about you:

- Rights of Access to Inspect and Copy. You have the rights, which may be restricted only in certain limited circumstances, to inspect and copy your PHI that we maintain. We may charge a reasonable, cost-based fee for copies.
- 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.
- Right to an Accounting or Disclosures. You have the right to request a copy of the required account of disclosures that we make of your PHI.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of you PHI for treatment, payment, or health care operations. WE are not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that we communicate with you in a certain way or at a certain location. We will accommodate reasonable requests and will not ask why you are making the request.
- Right to a Copy of this Notice. You the right to a paper copy of this notice.
- Right of Complaint. You have the right to file a complaint in writing with us or with the Secretary of Health and Human Services if you believe we have violated your privacy rights. *We will not retaliate against you for filling a complaint.*

Our Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations:

Treatment: We may use your PHI for the purpose of providing you with health care treatment. To coordinate and manage your care, we may disclose your PHY to other of you current providers. We may also disclose your PHI to other health care providers who become involved in your care.

Payments: We may use your PHI in connections with billing statements we send you and our system for tracking charges and credit to your account. In addition, but with your authorization, we may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability, as well as to submit claims for payment and medical necessity and utilization reviews.

Health Care Operations: We may use and disclose your PHI for the health care operations of our program in support of the functions of treatment and payment. Such disclosure would be to a Qualified Organization only or to a Business Associate/QSO (Qualified Service Organization) to provide services to the program and its patients for data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting. Or other professional services, or services to prevent or treat child abuse or neglect.

Uses and Disclosures That DO Not Require Your Authorization or Opportunity to Object:

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. For example, we must make disclosures to the Secretary of the Department of Health and Human Services of the purpose of investigating or determining our compliance with the requirement of the Privacy Rule.

Audit and Evaluation: We may disclose your PHI to a health oversight agency for activated authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations performing utilization and quality control. If we disclose PHI to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your PHI.

Medical Emergencies: We may use or disclose your PH in a medical emergency situation to medical personnel only.

Child Abuse or Neglect: We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Research: We may disclose your PHI for use in a research project that an institutional review board has determined to be of sufficient importance to outweigh the privacy intrusion, to be impractical without PHT, to have specified safeguards against further disclosure in reports or otherwise, and, among other provisions, to require destruction or de-identification of your PHI.

Criminal Activity on Program Premises/Against Program Personnel: We may disclose your PHI to law enforcement official if you have committed a crime on program premises or against program personnel or you have made a threat to commit such crimes. Such disclosure is limited to circumstance of the incident, including name, address, status as a patient, and last know whereabouts.

Qualified Service Organization: We may disclose your PHI to a Qualified Service Organization to provide certain services to the program and its patients, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy. IF a QSO has more than will be utilized, otherwise only a Qualified Service Organization Agreement will be used. In the case the services is from a health care provider performing service to treat you, a business Associate Agreement will not be utilized because you will have a direct patient-provider relationship.
Court Order: We may disclose your PHI if a court of competent jurisdiction issues an appropriate order.

Uses and Disclosures of PHI with Your Written Authorization:

We will make other uses and disclosures of your PHI only with your written authorization. You may revoke the authorization in writing at any time, unless we have taken a substantial action in reliance on the authorization such as providing you with health care services for which we much submit subsequent claim(s) for payment.

I have read and understand the HIPAA policies and understand that I can receive a copy if requested.

Signature of Patient	Date	Witness	Date
Parent/Guardian Signature	Date	Witness	Date

PATIENT RIGHTS AND RESPONSIBLITIES

Southlake Counseling and Consulting
Southlake Center for Self Discovery

Welcome to our Office

CONFIDENTIALITY

Privacy and confidentiality are of the utmost importance to the clinical relationship. Information given by the client remains private and confidential. The therapist will not share information with any person without your written permission, except as required by law or in a situation deemed potentially life threatening. I grant permission to the therapist to communicate with my emergency contact person if a situation is deemed potentially life threatening.

FINANCIAL

Insurance information needs to be current and accurate. You are expected to pay all deductibles and co-payment amounts at the time of each visit Clients are responsible for the payment of all applicable fees at the time of each visit. If you are the parent or guardian of a minor, all costs not covered by your insurance company will be your responsibility. The office does not become involved with division of accounts between divorced parents. Any service provided by *Southlake Counseling and Consulting* or *The Southlake Center For Self Discovery* is non-refundable.

APPOINTMENTS

Appointments are scheduled as a forty-five minute therapeutic hour. In the event that you must cancel an appointment, please call (704) 896-7776 at least 24 hours, preferably 48 hours in advance*. Failure to give 24 hour notice will result in your being billed in full for that session*. Insurance companies will not reimburse for missed appointments.

MANAGED CARE CLIENTS

Most managed care plans require pre-approval for mental health services. Noncompliance could lead to denial of benefits (payment for services). If you have entered therapy with this office under a managed care plan, please verify prior approval for services. Under some managed care plans, the therapist is required to provide clinical information to a case manger after the initial session if additional sessions are needed. If you have any questions about this procedure, please speak to the therapist.

_____ _____

Signature Date

Parental Agreement for Confidentiality of Adolescent Sessions

Dear Parent or Guardian,

A young person is more likely to disclose sensitive information to a counselor of he or she is provided with confidential services and has time alone with counselor to discuss his or her issues. The most practical reason for clinicians to grant confidentiality to an adolescent client is to facilitate accurate and appropriate treatment.

Experienced clinicians recognize that candid and complete information can be gathered only by speaking with the adolescent patient alone and by clarifying with whom the information will be shared. If an assurance of confidentiality is not extended, this may create an obstacle to the safe environment of the counseling relationship.

Some areas of teenage health that we may talk about during the appointment are:

- Diet, exercise, and body image
- Fighting, danger, and violence
- Sexuality and sexual behavior
- Safety driving
- Smoking, drugs, and alcohol
- Working/Jobs
- Depression and stress
- Peer pressure and school
- Relationships
- Family Life

I encourage teenagers to share information about their emotional and mental health with their parents or guardians. However, there will be some things that your teenage son or daughter would rather talk about exclusively with a counselor.

Work with an adolescent is generally more productive if parents voluntarily agree not to request information about the adolescent's private session. I ask your permission to keep what is discussed in our sessions confidential. "Confidential" means I will only share information with you if your teenage son or daughter says it's alright. The counselor agrees to share with the parent(s) any information which is necessary for the safety of the adolescent.

I agree that the therapist will determine that information, in his or her professional judgment, is appropriate to be shared with the parent/guardian(s) concerning treatment issues, and what information, in discretion of the therapist will remain confidential between my adolescent child and the therapist.

_____

Parent/Guardian Agreement Date

_____

Witness Date

Consent for Counseling Services to Minors

In order for minor children/adolescents to receive psychological services, it is necessary for the parent or legal guardian to grant permission for such services to occur.

Names and date of birth of child(ren) to receive psychological services:

Name_____Date of Birth_____

Name_____Date of Birth_____

Name_____Date of Birth_____

Name of person requesting services_____

Your relationship to children: Parent Stepparent Guardian Grandparent Other

Are you the legal parent or custodian to the above-named children? Yes No

I hereby swear that I have legal right to obtain treatment for the above-named children: Yes No

In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order with names you the legal custodian of the above children.

Are you willing to do so? Yes No

If the answer to any of the above questions is No, counseling services can not be provided to the above-named chil(ren) until a copy of the court order which names you the legal custodian is provided to the office.
I acknowledge that both natural parents, even though divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the child(ren).

- North Carolina State law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.
- This treatment may also include referral to other appropriate State and County agencies for further counseling.

I, _____, consent to _____ of Southlake Counseling and Consulting & Southlake Center for Self Discovery in providing psychological services to the child(ren) named above. The services may include: Clinical services, counseling/psychotherapy, or other services.

Signature of person authorizing consent Date

CONSENT FOR THE USE OF TELEMEDICINE

Telemedicine includes the use of specialized audio/visual equipment with a secure HIPPA compliant Internet connection, allowing Southlake Counseling to provide assessment and/or therapeutic services to individuals using staff who are located in a different office than the one where you may be currently located.

BENEFITS OF TELEMEDICINE:

- Improved access to services
- Improved specialty coverage such as psychotherapy
- The ability to obtain a consultation from a distance professional
- Security measures designed to ensure protection of privacy

POSSIBLE RISK OF TELEMEDICINE:

- Occasionally the speed that information is sent between the two locations slows which can cause poor image quality. In rare instances this can be enough to require the session to be ended.
- If the session must be ended this could cause a delay in evaluation and treatment (service may need to be rescheduled).
- Although very safe, in very rare instances security measures could fail resulting in a potential breach of personal medical information. (Southlake Counseling utilizes a HIPPA complaint video conferencing system.)

YOUR SIGNATURE BELOW CONFIRMS:

- I am aware of my right to withdraw my consent for telemedicine at any time during my care at Southlake Counseling without affecting my right for future services.
- I understand the same privacy laws to protect my information when I meet face-to-face with the provider governs telemedicine so my information will not be shared without my consent unless covered by the exceptions located in the notice of privacy practices given at the time of admission.
- I am aware that if my insurance does not reimburse for services rendered, I will be responsible for paying the full amount.
- I have had the alternatives to telemedicine explained to me and in choosing to participate in telemedicine, I am aware that some parts of the service may be conducted by individuals at my location at the direction of the telemedicine provider.
- I have read this form completely and understand the risk and benefits of telemedicine, I've had my questions answered and I hereby consent to telemedicine services at Southlake Counseling.

_____ _____

Signature of Person Served/Legal Responsible Party Date

Revocation of Telemedicine Services:

I wish to withdraw my consent for telemedicine services at Southlake Counseling as of _____.

_____ _____

Signature of Person Served/Legal Responsible Party Date

903 Northeast Drive, Suite 201
Davidson, NC 28036
704.896.7776 (P), 704.896.0992 (f)