PRESBY PSYCH

WHERE HOPE MEETS HEALING

NEW CLIENT PAPERWORK – CHILDREN AND ADOLESCENTS AGE 12 AND OLDER

We ask that you complete a number of forms, all listed here. We at Presby Psych want to provide the highest quality service possible so we ask that you fill out each form as completely as possible. Thank you!

- **Notice of Privacy Practices**
  Please keep for your records

- **Receipt for Notice of Privacy Practices (Both parents need to complete)**
  Please sign, date and return.

- **Informed Consent to Receive Psychological Services (Both parents need to complete)**
  Please complete, sign, date and return.

- **Informed Consent for In-Person Sessions during the COVID-19 Pandemic (Both parents need to complete)**
  Please complete, sign, date and return.

- **Proof of Vaccination**
  Please provide a copy of your child's vaccination card.

- **Credit Card Agreement**
  Please complete to leave your credit card on file for payment.

- **Child & Adolescent Parent Questionnaire**
  Please complete and return.

- **Demographic Information**
  Please complete and return.

- **Insurance Guidelines for New Clients**
  Please complete, sign, date and return if you plan to use your insurance coverage to pay for your sessions.

Presby Psych welcomes all individuals regardless of age, gender, race, ethnicity, faith, no faith or sexual orientation. We are a trauma-informed organization.

PRESBY PSYCH
WHERE HOPE MEETS HEALING

NOTICE OF THE PRIVACY PRACTICES OF PRESBY PSYCH

Introduction:

The privacy of your Patient Health Information (PHI) is important to us and we do everything possible to protect that privacy.

We have a legal responsibility under the laws of the United States and the state of North Carolina to keep your PHI private except as allowed or mandated by law. Part of our responsibility is to give you this notice about our privacy practices. We are also responsible for adhering to the practices herein described. This notice takes effect September 15, 2016 and will be in effect until we replace it. We have a right to change any of these privacy practices as long as those changes are permitted or required by law. When this occurs, the new policy will be posted in the public area of our office.

When you are finished reading this notice, you may request a copy at no charge to you. If you have questions or concerns about the material in this document, please ask us for assistance.

Privacy Protections:

Presby Psych complies with HIPAA guidelines relevant to the delivery of all our services.

Your PHI is accessed only by your providers and by other Presby Psych staff only to the extent that it is necessary to schedule, provide, record, and bill for services.

We will not use or disclose your PHI in our marketing, development or public relations efforts without your written permission.

We cannot use or disclose your PHI other than the ways detailed in this notice without your written permission.

Limits of Privacy:

We may disclose all or some of your PHI as follows:

If you choose to use insurance or another third party payor to help pay provider fees, some PHI will be released to the insurance company or other third party payor as required by that company or payor.

To anyone required by federal, state, or local laws to have lawful access to your PHI.

To anyone you give us written authorization to have your PHI. You may revoke that authorization at any time.

To a family member, or other person responsible for your care, or your personal representative in case of an emergency. If you are present and capable of objecting, you may do so. If you object, are not present, or are not capable of objecting, we will use our professional judgement in deciding whether or not to release the extent of PHI that is in your best interest and necessary for your care at the time.

Under North Carolina law, we are mandated to report to the Department of Social Services, and/or to law enforcement, and/or to the National Child Abuse Hotline known or suspected abuse, neglect, or maltreatment of a juvenile.

If you intend to take your own life, we will take steps to save your life, including disclosure of PHI to the extent that it is in your best interest at the time.

If you intend to take the life of another person, we are mandated to take steps to save their lives, including informing them, law enforcement, or other relevant third parties and we will disclose your PHI only to the extent that is in the best interests of you and the intended victim.

If your PHI is subpoenaed properly under state or federal rules.

We are required by federal law to make and keep a copy of your driver's license to protect your identity.

Internal Use of PHI:

In order to provide the highest quality care, Presby Psych clinicians meet weekly to share their clinical work. When clinical work is presented, all identifying data are disguised. If anyone present believes they may know the person being presented, they leave the room for the duration of the discussion.

Some PHI may be included in professional presentations, journal articles, research, training, grant applications, books, or development efforts. In these cases, all identifying data is disguised and the PHI of a variety of individuals is combined in a fictionalized composite case study.

Your Rights: *As our patient, you have these important rights:*

1. With limited exceptions, you may request in writing that we protect your PHI.
2. You may request photocopies of PHI for a charge of $.75/page for pages 1-25; $.50/page for pages 26-100; and $.25/page for pages 100+.
3. You have a right to a free copy of this notice.
4. You may request in writing that we communicate with you about your PHI through alternate means or at an alternate location by specifying the alternate means and/or location.
5. You may request in writing that we otherwise restrict use or disclosure of your PHI. We may deny any or all of your requested restrictions.
6. You may request in writing a list of occasions on which we, or our business associates, disclosed your PHI other than for treatment, payment, or Center operations. This can extend six years into the past. If you make this request more than once in a twelve-month period, we may charge you a fee for this service.
7. You have the right to restrict certain disclosures of PHI to a third party health plan if you pay out-of-pocket for the services you receive at Presby Psych.
8. If you believe that we have violated your privacy rights, or if you disagree with a decision we have made regarding your PHI, you may complain in writing to our HIPAA Compliance Officer, Patrick Collins, LCSW, LCAS, Presby Psych, 5203 Sharon Road, Charlotte, NC 28210.
9. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide the address upon request.

PRESBY PSYCH

WHERE HOPE MEETS HEALING

RECEIPT FOR NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Presby Psych's Notice of Privacy Practices.

_____ _____

Signature Date

PRESBY PSYCH

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Signature Date

PRESBY PSYCH

WHERE HOPE MEETS HEALING

INFORMED CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES AT PRESBY PSYCH

I am the:
- □ patient
- □ parent or legal guardian of the patient
- □ other (specify relationship) _____

CLINICAL PROCESSES AND DISCLOSURES

Clinical Emergencies: It is not always possible for your provider or another Presby Psych provider to respond to you in an emergency situation. If you cannot reach your therapist and are experiencing an emergency, you are to call 911 or proceed to your nearest Emergency Room.

Risks Associated with Treatment: In the course of receiving services, additional psychological material may surface which increases your level of distress for some period of time.

Treatment Outcomes: While the services provided by Presby Psych are intended to benefit the patient, no particular treatment outcomes can be guaranteed.

Right to Discontinue Treatment: You have the right to discontinue treatment at any time. We recommend, however, that you discuss these plans with your provider before making the decision to discontinue.

Complaints/Concerns: If you have complaints or concerns about the services being provided to you, please contact our Executive Director, Mary Gail Frawley-O'Dea, Ph.D., at 704-554-9900, ext. 304.

Disability Claims: Our providers will not complete patient disability claim forms for patients.

Goals and Processes of Treatment: Each therapist works with patients to improve mental health functioning. Each treatment, however, is unique. Please discuss your goals with your therapist. You are free to review at any time the progress you are making or any concerns you may have about the care you are receiving.

CHILD CARE

Presby Psych cannot provide child care. If a child is not part of a scheduled counseling session and there is no adult to care for the child, the provider may cancel the session and you are responsible for the fee for the canceled session. Insurance cannot be billed in this situation.

FINANCIAL POLICIES

Participating Insurance Plans: Presby Psych participates with Aetna, Blue Cross Blue Shield (except Blue Essentials, Blue Local, Blue Value and Value Options), Carolina Behavioral Health Alliance (CBHA), Cigna, and United Healthcare health insurance plans.

Insurance Verification and Filing: Presby Psych verifies applicable in-network benefits, co-pays and deductible status. We also file insurance claims with carriers with whom we participate. These are courtesies that do not guarantee coverage or payment. You are ultimately financially responsible for the services you receive.

A copy of your primary and secondary (if applicable) insurance cards will be made. It is your responsibility to provide Presby Psych with current insurance information or changes.

All fees not covered by insurance are due at the time of service. We recommend that you provide us with credit card information that allows us to bill your fees automatically. We will require you to do so if you accrue a balance exceeding 60 days.

Statements: Are sent at the beginning of each month.

Overdue Balances: Presby Psych is a non-profit mental health resource. It is important to stakeholders that we are responsible financial stewards. We therefore hold to the following policies regarding overdue balances:

Over 30 days: If a balance is outstanding for more than 30 days and an additional statement must be sent, a $10.00 fee will be added to the balance.

Over 60 days: We make every effort to make reasonable payment plans on accounts that exceed 60 days. When a balance exceeds 60 days, we require a signed payment plan and a credit card on file in order for treatment to continue. The agreed payment on the overdue balance and all future charges will be processed on that credit card. If such a credit card is declined, the balance must be paid in full at the next session.

Over 90 days: We reserve the right to report to all national credit bureaus any accounts that exceed 90 days and for which no payment plan is in place. You will receive 30 days notice prior to reporting and you will have an opportunity during that time to pay the balance in full or to arrange a payment plan.

Returned Checks: Returned checks are subject to a fee. If a check has been returned, we reserve the right to refuse further payments by check and to have a credit card on file for future charges.

Extra-Session Services: Therapists may charge separately per quarter hour for telephone conversations, consultations with school personnel, attendance at IEP meetings, off-site visits with other providers, or other extra-session services you and your provider agree to.

Cancellation Fees: We commit to providing the best care possible for those seeking our services. To do that, it is important that the individual(s) in our care attend every scheduled session; the success of psychotherapeutic work depends on the consistency of the meetings. In addition, clinicians have scheduled time for clients and cannot usually fill that time if there is a cancellation. Given the value we place on the work we do and the regularity that it requires, there will be:

A $75 charge for any canceled appointment that has not been previously arranged with the clinician.

The full session fee will be charged if you cancel the same day of the scheduled session, if you leave a cancellation message over the weekend for a Monday appointment, or if you fail to appear for a scheduled appointment.

Insurance cannot be billed for these fees nor can they be charged to any entity sponsoring your therapy.

Medical Record Copies: You will be responsible for fees associated with requests for copies of medical records. Charges will be assessed based on NC General Statutes and records will not be released until fee is paid.

ELECTRONIC COMMUNICATIONS/TELEPSYCHOLOGY

The governance, legalities, and ethics of electronic communication and provision of services through e-mail, text, Skype or other electronic means are still being discussed by professional bodies and various legislative groups.

It is often helpful to use electronic media to address scheduling issues or to communicate about limited clinical issues.

Privacy Safeguards: Clinician laptops, cell phones, ipads, or all other means of electronic communications are password protected. Passwords are changed every 90 days. Clinicians delete all PHI from their

computers daily. Patients using electronic means to communicate with therapists should also password protect their devices and delete communications as soon as possible after the communication ends.

Risks:

Presby Psych cannot guarantee the same security, confidentiality and privacy as is provided in face-to-face sessions.

There is an undeterminable risk that electronic communications may be intercepted by a third party and shared with others without your permission or the permission of Presby Psych.

E-mails or texts should not be used for emergencies or urgent issues.

PHI that is particularly sensitive should not be sent by e-mail or text, e.g. HIV, drug abuse, sexually transmitted diseases, pregnancy test results, etc.

Your employer may be able to view e-mails or texts sent or received at work.

E-mails or texts may not be delivered correctly.

Presby Psych Policies:

Some Presby Psych providers do not engage in electronic communications.

Presby Psych saves all e-mails addressing clinical issues that are sent by Presby Psych or are received by Presby Psych. They become part of the permanent medical record, just like a clinical phone discussion would. Skype sessions will be documented in the same way face-to-face sessions are.

Presby Psych is not responsible for breaches of privacy that occur if a patient allows a third party to access his/her e-mail or texts to or from Presby Psych.

Presby Psych is not responsible if a third party intercepts and distributes a patient's electronic communications to or from Presby Psych.

Insurance carriers will not cover phone sessions, Skype sessions or clinical discussions conducted through e-mail or text.

Please choose one:

- ☐ I do **NOT** want to communicate with my provider or anyone at Presby Psych via e-mail, text, Skype, or other electronic communications and do **NOT** grant permission to my provider or anyone at Presby Psych to do so with me.
- ☐ I **DO** want to communicate with my provider via electronic communications and **DO** give my provider permission to do so with me.

Divorced or Separated Parents: The parent or other caretaker bringing a child or adolescent to therapy is responsible for paying the fees associated with that session.

I have read the preceding Informed Consent terms and agree to accept services at Presby Psych under these conditions.

_____ _____

Patient Signature Date

_____ _____

Witness Date

PRESBY PSYCH

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Divorced or Separated Parents: The parent or other caretaker bringing a child or adolescent to therapy is responsible for paying the fees associated with that session.

I have read the preceding Informed Consent terms and agree to accept services at Presby Psych under these conditions.

_____ _____

Patient Signature Date

_____ _____

Witness Date

PRESBY PSYCH
WHERE HOPE MEETS HEALING

INFORMED CONSENT FOR IN-PERSON SERVICES DURING THE COVID-19 PANDEMIC CLIENTS 12 YEARS OLD OR OLDER

This document contains important information about our decision (yours, mine and Presby Psych's) to begin/resume in-person services in light of the COVID-19 public health crisis. Our decision is based in part on the recommendations by the Center for Disease Control (CDC) and the NC Department of Health and Human Services.

Please read this carefully and let us know if you have any questions. When you sign this document, it will be an official agreement between you and Presby Psych.

All Presby Psych clinicians and staff members are at least two weeks past full vaccination and our vaccination cards are on file. We will produce them upon request.

Decision to Meet Face-to-Face

Presby Psych clinicians will meet in-person only with clients 12 years old or older who are two weeks past full vaccination. If there is a resurgence of the pandemic or if other health concerns arise, however, Presby Psych may require a return to telehealth.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, the clinician will respect that decision as long as it is feasible and clinically appropriate. Reimbursement for telehealth services is also determined by the insurance companies and applicable law, so we will discuss any financial implications if needed.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep you, the clinician, your and our families, other Presby Psych staff members and other clients safer from exposure, sickness and possible death. Initial each to indicate that you understand and agree to these actions:

General Guidelines

_____ Presby Psych clinicians will meet only with individuals 12 years old or older who are two weeks past full vaccination. You are submitting a copy of your vaccination card with this informed consent.

_____ You will wait in the car outside the clinician's office until the clinician sends a text or beckons in some other way to have you come into the building or to an outside session.

_____ You will only keep your in-person appointment if you are symptom free.

_____ You will only keep your in-person appointment if you have been fever free for a minimum of 10 days prior to the appointment.

_____ You will cancel your appointment if you have been in contact with someone who has tested positive for COVID within the last 14 days.

_____ If you have a job that exposes you to other people who are infected, you will immediately let the clinician know.

_____ If a resident of your home tests positive for the infection, you will immediately let the clinician know and then treatment via telehealth will begin/resume.

_____ You will take your temperature before coming to each appointment. If it is elevated (100 degrees Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, you will not be charged our normal cancellation fee.

_____ If you arrive for a session and the clinician believes you are showing a fever or symptoms that could be related to COVID, the clinician will cancel the session and reschedule it for telehealth.

_____ You will wash your hands or use alcohol-based hand sanitizer when you enter the building.

_____ You will wear a mask in all common areas of Presby Psych offices – restrooms, stairways, halls.

_____ You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with any member of the Presby Psych staff or the clinician.

_____ You will take steps between appointments to minimize your exposure to COVID.

Presby Psych may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, the clinician will talk with you about any necessary changes.

Presby Psych's Commitment to Minimize Exposure

Presby Psych has taken steps recommended by public health officials to reduce the risk of spreading the coronavirus within the office. Please let the clinician know if you have questions about these efforts.

If the Clinician is Sick

You understand that Presby Psych is committed to keeping clients, the Presby Psych staff and all of our families safe from the spread of this virus. If the clinician or any Presby Psych staff member working in the building in which you are seen tests positive for the coronavirus, you will be notified so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, Presby Psych may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for your visits. By signing this form, you are agreeing that Presby Psych may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that you agreed to at the start of your work at Presby Psych.

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

_____ _____

Client Printed Name Date

_____ _____

Client or Parent/Guardian Signature Date

PRESBY PSYCH
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_____ You will take your temperature before coming to each appointment. If it is elevated (100 degrees Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, you will not be charged our normal cancellation fee.

_____ If you arrive for a session and the clinician believes you are showing a fever or symptoms that could be related to COVID, the clinician will cancel the session and reschedule it for telehealth.

_____ You will wash your hands or use alcohol-based hand sanitizer when you enter the building.

_____ You will wear a mask in all common areas of Presby Psych offices – restrooms, stairways, halls.

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

_____ _____

Client Printed Name Date

_____ _____

Client or Parent/Guardian Signature Date

PRESBY PSYCH

WHERE HOPE MEETS HEALING

PROOF OF VACCINATION

Please return a copy of your vaccination card along with these forms.

PRESBY PSYCH
WHERE HOPE MEETS HEALING

CREDIT CARD AGREEMENT

I, _____, hereby authorize Presby Psych to keep my credit card information securely on file and apply fees to it as follows:

- I authorize Presby Psych to apply fees or co-payments for services received.
- I authorize Presby Psych to apply fees for any services missed and not canceled within 24 hours of its scheduled time.
- I authorize Presby Psych to apply any fees that are unpaid after 45 days.
- I understand that I may revoke this agreement at any time.

We DO NOT accept American Express or Discover.

NAME	
CARD TYPE	
CARD NUMBER	
EXPIRATION DATE	
SECURITY NUMBER (on back of card)	
NAME ON CARD	
SIGNATURE	
DATE AUTHORIZED	
STREET ADDRESS	
CITY, STATE, ZIP	

PRESBY PSYCH
WHERE HOPE MEETS HEALING

CHILD & ADOLESCENT PARENT QUESTIONNAIRE

Please answer the following questions: **Date:** _____

CHILD'S INFORMATION

Full Name:	Preferred Name:
Date of Birth:	Gender: □ Male □ Female □ Other

Street address: _____
City: _____
State: _____ Zip: _____

PARENTS' INFORMATION

	Mother		Father	
Name:				
Date of Birth:				
Address:	□ Same as child		□ Same as child	
Address: (if different from child)				
		Message OK?		Message OK?
Cell Phone:		YES NO		YES NO
Home Phone:		YES NO		YES NO
Work Phone:		YES NO		YES NO
Email:				
Racial/Ethnic Identity:				
Marital Status:				
Occupation:				
Education:				

Child lives with: □ Mom and Dad □ Mom only □ Dad only □ Shared time

In case of emergency, we should contact: _____
Relationship: _____
Address: _____
Phone(s): _____

Referred here by: Relationship:

May we contact you by email? □ YES □ NO

PRESENTING PROBLEM

Please briefly describe your concerns about your child at this time:

Who thinks this is a problem: □ Me □ Other parent □ Child □ Teacher □ Pediatrician
□ Other: _____

Check any symptoms, or behaviors, your child has experience in the last six weeks:

- □ Fatigue
- □ Nightmares
- □ Bed wetting
- □ Insomnia
- □ Problems falling asleep
- □ Changes in appetite or eating habits
- □ Difficulty concentrating
- □ Often seems confused
- □ Difficulty completing homework
- □ Too talkative
- □ Engaging in self-harm behavior (cutting, burning
- □ Difficulty with transitions
- □ Difficulty understanding social situations
- □ Difficulty making friends
- □ Restless
- □ Irritable
- □ Anxious
- □ Fearful
- □ Impulsive
- □ Angry
- □ Isolated
- □ Shy
- □ Defiant
- □ Over-reactive or insensitive to other's feelings
- □ Excessive worries or fears
- □ Lacks self-confidence
- □ Expressed thoughts of killing self
- □ Difficulty understanding non-verbal behavior such as reading facial expression and body language

Do you have concerns about your child's eating or nutrition: □ YES □ NO
Has child ever suffered a head injury? Explain: _____
Has child been a victim of child abuse or sex abuse? □ YES □ NO
Has child participated in mental health treatment or counseling before? □ YES □ NO
If yes – Where? _____
When? _____
Why? _____
Has child been diagnosed with disorder? □ YES □ NO
If yes – explain: _____

ACADEMIC/EDUCATIONAL HISTORY

School: _____

Teacher: _____ Grade: _____

Has your child:	Been retained?	□ YES □ NO
	Been diagnosed as having learning disorder or learning issue?	□ YES □ NO
Does your child:	Have IEP?	□ YES □ NO
	Have 504 Plan?	□ YES □ NO
	Enjoy school?	□ YES □ NO

Number of schools child has attended: _____

SIGNIFICANT TRANSITIONS OR EVENTS IN CHILD'S LIFE

- □ Family Death
- □ Other Death
- □ Changed schools
- □ Child left home
- □ Marriage
- □ Marital Separation or Divorce
- □ Child: Serious illness/injury
- □ Family member: Serious illness/injury
- □ Family member deployed overseas
- □ Parent: Job Loss
- □ Significant change in family finances
- □ Home loss or move
- □ Grandparent moved in/needs changed

Has the child witnessed or experienced:	Current	Past	None
Physical abuse			
Sexual abuse			
Emotional/psychological abuse			
Physical neglect			
Emotional/psychological neglect			
Witnessed domestic violence			
Household member abusing drugs or alcohol			
Household member with mental illness			
Parents separated or divorced			
Household member incarcerated			

DEVELOPMENTAL HISTORY

Have you or someone else had concerns about your child's:

□ Physical development □ Fine motor development □ Gross motor development
□ Language/speech skills □ Sensory integration

MEDICAL HISTORY

Pediatrician or family physician: _____
Practice: _____ Phone: _____
Date of latest physical: _____

Please list any medications your child is taking:

Medicine	Provider Prescribing	Purpose of Medication

FAMILY MENTAL HEALTH HISTORY

Have you and/or your spouse/partner ever been diagnosed with a psychological/psychiatric disorder (e.g. depression, anxiety, obsessive-compulsive disorder, ADHD)? □ YES □ NO

If so, did you and/or your spouse/partner seek treatment (psychotherapy, medication, other)?
□ YES □ NO

Do you believe either you and/or your spouse/partner struggles with alcohol and/or drug use (past or present)? □ YES □ NO

Were you or your spouse/partner a child in a family where alcohol and/or drugs was problematic?
□ YES □ NO

Has anyone in your family been diagnosed and/or treated for a psychological/psychiatric disorder?
□ YES □ NO

If so, please identify the family member and condition (if known):

Has a family member(s) attempted suicide (e.g., tried to commit suicide by overdosing on pills)?
□ YES □ NO

Has a family member(s) died by suicide? □ YES □ NO
If yes, what relative(s) died by suicide and when?

Were you or your spouse/partner ever physically, emotionally, and/or sexually abused? □ YES □ NO
If yes, when did the abuse occur and who was the perpetrator (if known):

Has anyone in your family ever been accused of molesting, fondling, and/or abusing a child, adolescent, or young adult? □ YES □ NO

LIVING ARRANGEMENTS

At present, who lives in the child's household:

Name/Gender	Age	Relationship to child (e.g. mother)	Occupation	Education

Please list any other siblings not living in the home:

Name/Gender	Age	Relationship to child (e.g. mother)	Occupation	Education

Please ask our receptionist or your therapist to make a copy of your driver's license, which we are required by law to have on file.

DEMOGRAPHIC INFORMATION

Much of the funding for Presbyterian Psychological Services comes from grants. Often, a grant application must be accompanied by demographic information about our patients. We would appreciate it if you would complete this form. It is an anonymous form, it will not be placed in your chart, and is used only to collect demographic information. Thank you.

Please place an "X" in the box that best answers the question.

AGE and GENDER of the PATIENT who will be seen here.

□ Male □ Female □ Other

□ 0 – 9 □ 10 – 19 □ 20 - 29 □ 30 - 39 □ 40 - 49 □ 50 - 59 □ 60 – 69 □ 70+

RACE/ETHNICITY of the PATIENT who will be seen here.

□ African-American □ Asian □ Caucasian □ Hispanic □ Native American □ Other

ANNUAL HOUSEHOLD INCOME for your family.

□ < $10,000 □ $10,000 - $24,000 □ $25,000 - $49,000 □ $50,000 - $74,000 □ $75,000 - $99,000 □ > $100,000

REFERRAL SOURCE A: How were you referred to Presby Psych?

□ Therapist or Mental Health Resource □ Insurance company or insurance website □ Internet or Presby Psych website

□ Pastor or church staff □ Physician or physician's office* □ Relative or Friend

□ Psychology Today – Presby Psych □ Psychology Today – Specific Therapist □ Other

*REFERRAL SOURCE B: If referred by a physician or physician's office, which medical group?

□ Atrium Health (formerly CMC) □ Novant Healthcare □ Other □ Do not know

EARLY EXPERIENCES:

Did you experience any of the following *BEFORE THE AGE OF 18?*

□ Physical Abuse □ Sexual Abuse □ Emotional/Psychological Abuse □ Physical Neglect

□ Emotional/Psychological Neglect □ Witnessed domestic violence □ Household member abusing drugs/alcohol

□ Household member with mental illness □ Parents separated or divorced □ Household member incarcerated

If you are now over 18, do you feel these experiences continue to have an impact on you? □ Yes □ No

If yes, to what degree do they continue to impact you?

□ A great deal in general □ A great deal in certain areas of life

□ Moderately in general □ Moderately in certain areas of life

□ Slightly in general □ Slightly in certain areas of life

THANK YOU!

Presby Psych welcomes all people regardless of age, gender, race, ethnicity, faith, no faith or sexual orientation.

PRESBY PSYCH
WHERE HOPE MEETS HEALING

INSURANCE GUIDELINES FOR NEW CLIENTS

PLEASE NOTE: WE DO NOT PARTICIPATE AND/OR FILE CLAIMS TO MEDICARE OR MEDICAID

Please make sure you have completed the following steps if you wish to use your insurance coverage at Presby Psych):

1. Please contact your primary insurance company to determine your benefit coverage **BEFORE** your first session and any additional policies in order of coverage. **This is your responsibility, not that of Presby Psych.**

2. Ask the following questions, and write down the answers:

   - **Do I have Mental Health Benefits?** ❑ Yes ❑ No
   - **If the answer is NO,** then please ask your therapist about a sliding scale fee.
   - **If the answer is YES,** then share the following information with your insurance company:

     1. My therapist is _____ with the group of Presby Psych, Tax ID 561061160.
     2. Ask: Is he/she in or out of network?

        a. **If the answer is NO (or your therapist is OUT OF NETWORK and you do <u>not</u> have Out of Network benefits),** then please ask your therapist about a sliding scale fee.

        b. **If the answer is YES (or your therapist is <u>IN NETWORK</u> or you <u>do have</u> Out of Network benefits),** then please ask the following:

           1) Does my plan cover individual, marital and family counseling? ❑ Yes ❑ No
           2) What is the time frame of the benefit year? _____
           3) Do I have a deductible? ❑ Yes ❑ No
              a) If **YES,** does my deductible apply to my mental health benefits? ❑ Yes ❑ No
              b) What is the deductible amount? _____
              c) How much of my deductible has been met? _____
           4) What is my co-payment? _____
           5) What is the address to file mental health claims? _____
              _____
           6) Do I need an authorization or to pre-certify? ❑ Yes ❑ No
           a) If **YES,** indicate authorization number: _____
              How many visits does this authorization cover? _____
              How many visits are allowed per year? _____
           7) Name of person I spoke with: _____
           8) Date: _____

   - Please bring this completed form to your first visit.

I have read and understand the above information:

_____ _____

Name Date