West Counseling, PLLC

Name: **Medicaid ID #:** **Record #:**

GENERAL INFORMATION

NAME _____

AGE ____ GRADE ___ EMPLOYER/SCHOOL _____DATE OF BIRTH _____

ADDRESS _____
Street City State Zip

HOME PH _____ WORK PH _____CELL PH _____

EMAIL:

Insurance Info:
Name of insured: _____ Policy/ID #:_____Group #_____

Phone number:_____Address:_____

Policy holder Name:_____DOB:_____Employer:_____

Co Pay:_____ Co Insurance:_____ Deductible_____

Secondary Insurance info:
Name of insured: _____ Policy/ID #:_____Group #_____

Phone number:_____ Address:_____

Policy holder Name:_____ DOB:_____ Employer:_____

Co Pay:_____ Co Insurance:_____ Deductible_____

Receive Reminder cell text? □YES □ NO Receive reminder emails □YES □ NO,(if yes sign up for Patient Portal) MAY WE LEAVE MESSAGES AT HOME/Cell/Work (circle one) □YES □ NO

(If consumer is a child)

PARENT/LEGAL GUARDIAN_____Ph# _____

PARENT/LEGAL GUARDIAN_____ Ph# _____

Primary Care Physician office:_____Ph#_____

Allergies:_____.

IN CASE OF EMERGENCY, PLEASE CONTACT:
NAME:/(& Relationship) _____Ph#:_____

PLEASE LIST OTHER FAMILY MEMBERS IN THE HOME & THEIR AGE & RELATIONSHIP TO THE PATIENT:_____

_____

ReferralSource:_____Date:_____NPI:___
_____ **Other:**

_____

West Counseling, PLLC

Consent to Treat

Name: Medicaid ID #: Record #:

I, (relationship to Consumer)_____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at West Counseling, PLLC, hereby referred as the Center. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Center non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Center is protected by Federal and/or State law and regulations. Generally, the Center may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access certain client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements with West Counseling, PLLC.

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 14 years of age, a legally responsible adult acting on his/her behalf must sign. Minors over 14 years of age must consent along with legally responsible adult)

_____ _____

Witness Date

I also consent for you to disclose information relevant to payment activities to the person responsible for payment of my bills (guarantor) if different from myself

_____.

(Guarantor Name)

West Counseling, PLLC

REVOCATION SECTION

I do hereby request that this consent to disclose health information of

_____

(Name of Client)

signed by_____ on _____ be rescinded,

(person Who Signed Consent) *(Enter Date of Signature)*

effective _____. I understand that any action taken on this consent prior to the rescinded date is legal and binding. *(Date)*

_____

(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this consent by

_____

(Name of Client or Personal Representative)

on _____. The client or his/her personal representative has been informed that any action

(Date)

taken on this consent prior to the rescinded date is legally binding.

_____

(Signature of Staff) (Date) *(Date)* *(Signature of Witness)* *(Date)*

**Treatment* means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

***Payment* means to obtain or provide reimbursement for the provision of health care; determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing; review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services; and disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: name and address; date of birth; Social Security Number; payment history; account number; and name and address of the health care provider and/or health plan.

****Health Care Operations* include conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and clients with information about treatment alternatives; related functions that do not include treatment; reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; business planning and development such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, and development or improvement of methods of payment or coverage policies; and business management and general administrative activities of the entity, including, but not limited to: management activities relating to implementation of and compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; resolution of internal grievances; the sale, transfer, merger, or consolidation of all or part of a covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and creating de- identified health information and fundraising for the benefit of the covered entity.

West Counseling, PLLC

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information. Effective 02-01-2010, Rev. 12/2017

Our Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements or by agreement.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, threat of terrorism or homeland security threat and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $3.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing. Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom. Request this in writing. If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

Complaints If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to 901 S. New Hope Road, Gastonia, NC 28054, 1-888-235-4673 , and/or the North Carolina Department of Mental Health/Mental Retardation or the U.S. Dept. of Health and Human Services. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: ATT: Policy Administration-2324 Concord Lake Rd, Concord, NC 28025

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signature(responsible party): _____ Date: _____/_____/_____

Signed by: __client __guardian __personal representative

West Counseling, PLLC

Financial Policy

The staff at West Counseling, PLLC (here after referred to as the clinic) are committed to providing caring and professional health care to all of our clients. As part of the delivery of health services we have established a financial policy which provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form, Financial Policy/*Payment Contract for Services,* which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the clinic will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amount covered, and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered or that you have not met your deductible. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Initial intake/Comprehensive Clinical Assessment $150, Therapy services are $47.50 per ½ hour, Clinical Services are up to $95 per hour, Court testimony is charged up to $1200 per day plus reasonable travel and accommodation cost. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates, we do accept insurance assignment. Clients will be considered for income sensitive adjustments per request and upon mutual agreement.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 30 days are subject to collections. A 10% per month interest rate is charged for accounts over 60 days.

Insurance deductibles, co-payments and Coinsurance are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized to an approved insurance plan, credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment May be charged at a rate noted in the Payment Contract for Services, this does not apply to insurance billing or government based insurance i.e. Medicaid/Medicare. In general, Individuals will be charged up to $55 for missed appointments. Those on Government insurances will be charged up to $5 for missed appointments.

Payment methods include check, cash, or Visa, MasterCard, Discover Card. Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session. Questions regarding the financial policies can be answered by the Manager.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____ Date: _____/_____/_____

Co-responsible party: _____ Date: _____/_____/_____

West Counseling, PLLC

2324 Concord Lake Rd, Concord, NC 28025/ PH 704-918-1343 Fax 704-461-4334

Consent to the Release of Information

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____DOB: __/____/__

_____, *authorize* **West Counseling to:_____ (send) _____ (receive)**

(relationship to the above)

Yes	No	Provider/Agency Name
❒	❒	_____
❒	❒	_____
❒	❒	_____
❒	❒	_____
❒	❒	_____

*SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.*

____ Academic testing results
____ Behavior programs
____ Progress reports
____ Intelligence testing results
____ Medical reports
____ Personality profiles
____ Psychological reports
_____ Medical: History/Physical
____ Psychological testing results
____ Service plans
____ Summary reports
____ Vocational testing results
____ Entire record, except progress notes
____ *Psychotherapy Notes
____ Psychiatric Assessments
____ Other; specify_____

The above information will be used for the following purposes:

____ Planning appropriate treatment or program
____ Continuing appropriate treatment or program
____ Assessments
_____Determining eligibility for benefits or program
_____ Case review
____ Updating files
____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. No information pertaining to STD's or Sexually transmitted diseases, HIV or Aids will be released without the express written permission of the consumer. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization

Your relationship to client:* __ *Self* __*Parent/legal guardian* __*Personal representative* __*Other (describe)

_____If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature:_____ **Date:** _____/____/_____

Parent/guardian/ Signature:_____ **Date:** __/____/_____

Witness (if client is unable to sign) Signature: _____**Date:** _____/____/_____

West Counseling, PLLC

REVOCATION SECTION

I do hereby request that this consent to disclose health information of

_____

(Name of Client)

signed by_____ on _____ be rescinded,

(person Who Signed Consent) *(Enter Date of Signature)*

effective _____. I understand that any action taken on this consent prior to the rescinded date is legal and binding. *(Date)*

_____

(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this consent by

_____

(Name of Client or Personal Representative)

on _____. The client or his/her personal representative has been informed that any

(Date)

action taken prior to the rescinded date is legally binding.

_____

Signature of Staff) (Date) *(Date)* *(Signature of Witness)* *(Date)*

West Counseling, PLLC

Name: **DOB:** **Medicaid ID #:** **Record #:**

TREATMENT PLAN SIGNATURES / Service Order

I. Consumer:

☐ I confirm and agree with my involvement in the development of this treatment plan. My signature means that I agree with the services/supports to be provided.
☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this treatment plan.

Legally Responsible Person: Self: Yes ☐ No ☐
Person Receiving Services: (Required when person is his/her own legally responsible person)
Signature: _____ _____ Date: __/__/____
(Print Name)

Legally Responsible Person (Required if other than person receiving Services)
Signature: _____ _____ Date: __/__/____
(Print Name)

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR Treatment plan:

Signature: _____ _____ Date: __/__/____
(Person responsible for treatment plan) (Name of provider)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the treatment plan attest that he or she has completed the following requirements as specified below:

☐ Met with the Child and Family Team - Date: __/__/____
☐ **OR** Child and Family Team meeting scheduled for - Date: __/__/____
☐ **OR** Assigned a TASC Care Manager - Date: __/__/____
☐ **AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for treatment plan:
☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ _____ Date: __/__/____
(Person responsible) (Print Name)

II. SERVICE ORDERS:

***REQUIRED** for all Medicaid funded services; **RECOMMENDED** for State funded services.*
For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).
My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The **licensed professional** who signs this service order has had direct contact with the individual. ☐ Yes ☐ No
- The **licensed professional** who signs this service order has reviewed the individual's assessment. ☐ Yes ☐ No
-

Signature: _____ _____ License #: _____ Date: __/__/____
(Name/Title Required) (Print Name)

Outpatient counseling to included ___ Individual Counseling ___ Family Counseling __ Grp Counseling (if available)