Center for Personal Growth

Your Success is Our Success.

709 Peninsula Drive Davidson, NC 28036
(Office) 704-655-2828 (Fax) 704-655-2830

CLIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Nick Name: ______________________ Sex: M:☐ F:☐ Other:☐ (Check one)

Client's Date of Birth: __________ Age: ________ Social Security: __________

Address: ____

City: ______________________ State: ______________________

Zip: ______________________ County: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Email: ____

Employer: ______________________ Occupation: ______________________

Work Phone: ______________________ Work Email: ______________________

Marital Status: Single:☐ Married:☐ Divorced:☐ Separated:☐ Widowed:☐ (Check one)

Ethnicity: ____

Number of Children and Ages (If applicable):

____

____

Do you have any active or past court involvement (RE: Custody Arrangements)? ☐ : Yes ☐ : No

Please select the method that is the best for rapid communication.

Check all that apply:

☐ : Email ☐ : Home Phone ☐ : Cell Phone ☐ : Work Phone ☐ : Work Email

Please select the method that you give our office permission to leave a message.

Check all that apply:

☐ : Email ☐ : Home Phone ☐ : Cell Phone ☐ : Work Phone ☐ : Work Email

Please select the method by which you would like to receive your appointment reminders.

Check all that apply:

☐ : Email ☐ : Text ☐ : Phone Call

Emergency Contact:

First Name: ______________________ Last Name: ______________________

Relationship to Client: ____

Home Phone: ______________________ Cell Phone: ______________________

Guardian (If applicable):

First Name: ______________________ Last Name: ______________________

Phone #: ____

Relationship to Client: ____

Primary Care Physician:

Physician Name: ______________________ Practice Name: ______________________

Address: ____

City: ________________________ State: ________________________
Zip: ________________________ County: ________________________
Phone Number: ____________________ Fax Number: ____________________

Caseworker/Care Coordinator (If applicable):

First Name: ____________________ Last Name: ____________________

Phone #: ____________________ Fax #: ____________________

Email: ____

Referred by:

Name: ____________________ Practice Name: ____________________

Phone #: ____________________ Fax #: ____________________

INSURANCE INFORMATION

Primary Insurance Company: ________________________________
Member ID #: ____________________ Group #: ____________________
Insured's Name: ________________________________
Insured's Date of Birth: ________________________________
Insured's Address: ________________________________
Relationship to Client: ________________________________

Secondary Insurance Company: ________________________________
Member ID #: ____________________ Group #: ____________________
Insured's Name: ________________________________
Insured's Date of Birth: ________________________________
Insured's Address: ________________________________
Relationship to Client: ________________________________

CLIENT RIGHT AND RESPONSIBLITES

Identification

At each appointment please have with you and be ready to present your insurance card, driver's license, or another form of identification. Failure to present your insurance card at the first appointment may result in the transference of the responsibility for payment from the insurance company to the client. Our office is unable to file insurance claims without a valid insurance card on file. Clients should be willing and able to provide their insurance card and a form of identification at all times.

By signing this document, you give us permission to take your picture on the day of your first appointment. This is a security measure that all clients must undergo. The picture, attached to your client file, is an additional measure taken to provide the utmost level of privacy and confidentiality to our clients.

Lobby Etiquette

To ensure a calm and quiet environment for all clients, we ask that no phone calls be made and/or taken in the lobby. If a phone call must be made and/or taken, we ask that you step outside to do so.

Please do not leave children unattended in the lobby for any reason or length of time. If you choose to leave your child or children unattended in the lobby, we are not responsible for their care or safety. In the event of disruptive behavior in the lobby, we reserve the right to interrupt your session and ask for your assistance to ensure a respectful environment for all clients.

Insurance Policies & Financial Responsibilities

As a courtesy, we will verify your mental health insurance benefits prior to your first appointment however we strongly recommend that they be checked by you in advance of your appointment. Verification of benefits and/or prior authorizations does not guarantee payment from your insurance company. 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 to be charged, where records are sent, etc. **You are responsible for knowing and understanding the terms of your Mental Health benefits & getting all referrals and/or authorizations required prior to your visit**. We need all the information on the attached demographics sheet filled out, as well as a copy of your insurance card. If the time frame for submission of a claim lapses due to incorrect and/or incomplete information, you are responsible for all fees.

Be aware you may be limited by your policy in the number of mental health visits per year therefore it is important that you know how many mental health visits your plan has allotted you. You may have a dollar limit ("cap") or your mental health benefits might be covered/paid by a different insurance plan than your medical plan, of which we may not participate so OUT-OF-NETWORK benefits, if offered, may apply. Failure to provide your insurance or updated insurance information will result in you being responsible for the full fee. **You are responsible for all fees not paid by your insurance.** Your insurance company does not guarantee payment of the claim until it is received; the amount owed by you may change once the claim is processed by your insurance. All claims are processed on an individual basis.

Deductible payments, co-pays and/or co-insurance amounts are due at time of service. Any balance due once your insurance company processes your claim is due **BY YOU** immediately. You are responsible for providing current financial/insurance information at the time of each visit. You will be billed based upon your presentation of current insurance at the time of each visit. We will not back bill nor take write offs based upon your failure to inform us of your current insurance at the time of each visit. We reserve the right to deny service based upon your current insurance or financial situation. **If your insurance fails to pay on a timely basis (within 30 days), we will send you a Statement of Account notifying you that your claim is unpaid, and the balance is due by you immediately.** From that point (i.e. after the 30-day period), you must work with your insurance company/employer in pursuing your benefits**.**

Non-Medicaid Clients: A credit card or debit card is **REQUIRED** on file and will be used for deductibles, co-pays, and co-insurance fees at the time of service. If at any time you wish to use a card other than the one on file you are responsible for presenting that card to the practice manager prior to the start of your appointment. Payment is due at the time of service, unpaid fees/co-payments will result in you being discharged from the practice and submitted to a collections agency. Checks may be made out to Alloway Consulting, PLLC. There is a $35 service charge for Returned/non-sufficient funds.

Cancellation & No Shows

You are responsible for knowing when your appointment is. As a courtesy, we send reminders via email and/or text before your appointments. Appointment reminders of any kind are not guaranteed therefore you are responsible for knowing the date and time of your appointment.

We require 48-hours' notice for all cancellations and reschedules. If your appointment is on a Monday, you must call our office the Friday before to be in compliance with our policy. A late cancellation or no-show has an impact; If we have enough notice of a cancellation, we can use that allotted appointment time to provide help to someone else. A late cancellation or no-show, without notice, means that we are unable to serve another client. As a result, we charge **$125 for a no-show or late cancellation** (i.e. less than 48 hours' notice). This fee is **not** covered by insurance and is due prior to any future scheduled appointments. This fee does not apply to clients that have Medicaid.

After three consecutive no-shows and/or late cancellations, we reserve the right to deny you services in our practice and will discharge you from our practice. Client's arriving 15 minutes past their scheduled appointment time will need to be rescheduled and will be charged a $125.00 fee that is not negotiable.

Recurring appointments (i.e. weekly, biweekly, or monthly) are a privilege and can be rescinded if the client misses two of these appointments without proper cancellation (i.e. less than 48 hours' notice). The clinicians' schedules fill up quickly and those requiring recurring appointments need to be respectful of others who require the same service. If this privilege is revoked by our practice, the responsibility of scheduling weekly/biweekly/monthly appointments falls on the client.

A credit card or debit card is **REQUIRED** to be on file to charge for no-show/late cancelled appointments if you cannot be reached regarding payment.

Crisis & Emergencies

During office hours, please direct all calls to (704)655-2828 if you are experiencing a mental health crisis. In compliance with DMA policy 8C, the phone number for our **after-hours, 24/7 services** is **704-430-8855**. This after-hours service is for **crisis calls** only. This means situations where there is a **risk of immediate harm** to someone. One can always call 911 or go to the nearest emergency room if experiencing a medical or mental health emergency.

Phone Calls

Clinicians are available by phone by appointment **ONLY**, this helps us to ensure the best quality of care is afforded to all our clients. Our Practice Manager is available by phone (704-655-2828) during normal business hours to address any administrative, scheduling, or billing concerns.

Communication between our clinicians and a third party (i.e. doctor, lawyer, previous therapist, etc.) may be subject to a $15 minimum charge and need to be scheduled in advance. These services are not covered by insurance.

Records

Forms, letters, reports, any correspondence/involvement, etc. are subject to an administrative charge ($25). Our Practice Manager is happy to complete these forms.

You may request access to your health information and medical records at any time. We ask that you complete a record request form or call (704) 655-2828 to begin the process. There are limited circumstances where we may deny you access to portions of your records. If you request copies, we will charge you $25. We will also charge you for our postage costs, if you request that we mail the copies to you.

If you have any questions or concerns about any of the above listed policies, feel free to speak with our practice manager, Katie S. Janvrin.

Your signature below indicates that you agree to, approve, and understand ALL our practice polices.

____ Signature of Client or Legal Representative

____________________ Date

Receipt of Privacy Notice (HIPPA)
Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

NAME:
BIRTHDATE:

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.

Your Rights Regarding Your PHI:

- **Rights of Access to Inspect and Copy.** You have the right, 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 PHI to other 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 the Center for Personal Growth 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 office and its Clients for data processing, bill collecting, legal, medical, and accounting or other professional services.

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 PHI 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 Premises/Against Office Personnel:** We may disclose your PHI to law enforcement official if you have committed a crime on Center for Personal Growth premises or against Center for Personal Growth 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 Client, and last known whereabouts.
- **Qualified Service Organization:** We may disclose your PHI to a Qualified Service Organization to provide certain services to the Center for Personal Growth and its Clients, such as data processing, bill collecting, legal, medical, and accounting or other professional services. IF a QSO has more than will be utilized, otherwise only a Qualified Service Organization Agreement will be used. In the case the services are from a health care provider performing service to treat you, a business Associate Agreement will not be utilized because you will have a direct Client-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.

I request the following restrictions to the use or disclosure of my health information:

____

____

I hereby authorize the following individuals to have access to my health records upon request:

____

____

Your signature below indicates that you have read and understand the HIPPA Policies and understand that you can receive a copy if requested.

________________________________ ________________

Signature of Client or Legal Representative Date

PAYMENT METHOD

CLIENTS MUST PROVIDE A VALID CREDIT or DEBIT CARD. THIS IS NOT OPTIONAL.

WE DO NOT CARRY CLIENT BALANCES.

ALL FEES ARE DUE AT THE TIME OF SERVICE.
A VALID CREDIT CARD OR DEBIT CARD IS REQUIRED BY ALL NON-MEDICAID CLIENTS.

*****In the event of missed appointments without proper 48-hour cancellation, or any co-pays, co-insurances or deductible amounts due at time of service, please charge fees to the following card:**

______ VISA

______ MASTERCARD

______ DISCOVER

______ AMERICAN EXPRESS

______ FLEX SPENDING ACCOUNT

Name (as it appears on your credit card): ____

Card Number: ____ Expiration date: ________________________

3-digit security code on back of card (CVV): ____

Billing Address: ____ Billing Zip Code: __________________

Cardholder or Authorized User Signature: ____

PLEASE NOTE: You must inform the office if there have been **ANY** changes to your credit card information. Failure to inform the office of such changes or a denied credit card transaction will result in a $125.00 charge to your account.

By signing below, you agree to, approve, and understand ALL of the following:

- Alloway Consulting, PLLC dba Center for Personal Growth, reserves the right to charge the credit card on file, at any time for services provided by the company.
- If your account at Alloway Consulting, PLLC dba Center for Personal Growth carries an outstanding balance for more than 30 days, we may charge the card for the outstanding amount without giving prior notice.
- You have the right to request an invoice/statement at any time.
- Alloway Consulting, PLLC dba Center for Personal Growth will not be held liable for any fraudulent charges made to the credit card account.
- If you are not the cardholder of the credit card, you agree to take full responsibility for any charges made by Center for Personal Growth to the card you have provided.

____ ______________________
Signature of Client or Legal Representative Date

CONSUMER RIGHTS / DISABILITY RIGHTS & CONTACTING OF NC STATE OFFICES:

When you receive services from the public mental health, developmental disabilities, and substance abuse services system, you have many rights supported in law. Understanding your rights will help you stand up for yourself and fully participate in your care. Knowing your rights can help you:

- **Make informed choices about your care.**
- **Resolve any problems that may occur.**
- **Know what to expect from your service provider.**
- **Become a better self-advocate for your care and recovery.**

A DECLARATION OF BASIC CLIENT RIGHTS:

Some of your basic rights are in North Carolina Law. North Carolina Law states "It is the policy of the state to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect and exploitation."

It is further the policy of this State that "each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth the program to maximize the development or restoration of his capabilities."

YOU ALSO HAVE THE FOLLOWING RIGHTS:

By law, you must be informed of all your rights within the first three visits to your community provider (or within the first 72 hours if you are in a 24-hour facility.) You may also have the right to:

- **Every voluntary client or legally responsible person has the right to consent or refuse treatment/habilitation in accordance with G.S. 122C-57(d). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility.**
- **Ask that printed information explaining your rights be given to you in a way that you can understand.**
- **Know what to do and whom to call if you believe someone is trying to take away your rights.**
- **You must be told about any rules you will need to follow. This information should be shared with you when you begin receiving services. If you do not receive this information, ask someone you trust to help you.**
- **Staff should be polite, attentive, and responsive to your needs and values.**
- **It is your right to receive care in your community in the least restrictive environment suitable to your individual needs.**

State Office of DWI Services:
www.ncdhhs.gov/mhddsas/dwi
3008 Mail Service Center
Raleigh, NC 27699-3008
Ph: 919-733-0566 Fax: 919-508-0963

North Carolina Division of Mental Health / Developmental Disabilities / Substance Abuse Services
www.ncdhhs.gov/mhddsas
Advocacy and Customer Service Section: 919-715-3197
DHHS CARE-LINE: 1-800-662-7030 (Voice/Spanish)

North Carolina Substance Abuse Professional Practice Board
www.ncsappb.org
P.O. Box 10126 Raleigh, NC 27605
Ph: 919-832-0975 Fax: 919-833-5743 Anna Bridgers Misenheimer, Executive

Disability Rights NC
www.disabilityrightsnc.org
2626 Glenwood Avenue, Suite 550, Raleigh, NC, 27608
(877) 235-4210 or (919) 856-2195
Email: info@disabilityrightsnc.org

My signature below indicates that I have read and understand all the above.

__________________________________ __________________________________
Signature of Client or Legal Representative Date