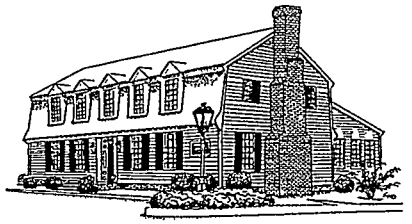

WAYNESBORO FAMILY CLINIC, P.A.

Behavioral Medicine - Family Psychotherapy

1706 WAYNE MEMORIAL DRIVE • GOLDSBORO, N.C. 27534-2240 • (919) 734-6676

To Our Clients:

We are in the process of updating ALL of our client profiles as we begin transitioning to new and improved software. While we are excited for this change, as it will help us better serve you, we will be asking for your understanding and patience during this time.

Please complete the following information as accurately and with as much detail as possible.

This information is **necessary** for our new program.

Thank you in advance for your participation and patience.

- the Staff of Waynesboro Family Clinic

Demographic Information

Full Name: _____ (First) _____ (Middle) _____ (Last)

Date of Birth: _____ Social Security No.: ___-___-___ Sex: M or F

Marital Status: Single Married Divorced Widowed Life Partner Common Law Domestic Partner

Race:
___ American Indian/Alaska Native
___ Black or African American
___ White or Caucasian/Euro American
___ Other: _____
___ Asian
___ Native Hawaiian/Other Pacific Islander
___ Latino

Ethnicity: ___ Hispanic/Latino ___ Not Hispanic/Latino

Mailing Address: _____ (Street or PO Box) _____ (City)

State: _____ Zip Code: _____ County: _____

Parent/Guardian: _____ (First) _____ (Middle) _____ (Last)

Home Phone: _____ Cell Phone: _____ Other : _____

Email Address: _____

Preferred Method of Contact: _____

Employment/School Information

Employer/School Name: _____

Full Time Part Time Active Duty Military Retired Not Employed Full Time Student

Part Time Student Self-Employed Disabled

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Health Insurance Information

Primary Insurance: _____

Policy Holder: _____ Policy Holder DOB: _____

Policy No.: _____ Group No.: _____

Secondary Insurance: _____

Policy Holder: _____ Policy Holder DOB: _____

Policy No.: _____ Group No.: _____

Primary Care Provider

Name: _____

City: _____

Phone No.: _____

Fax No.: _____

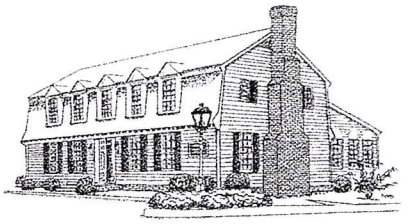
Pharmacy

Name: _____

City: _____

Phone No.: _____

Fax No.: _____



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CONSENT FOR TREATMENT

1. I have been fully informed of my rights as a client of this agency, the extent and limits of confidentiality in therapy, and the goals associated with this therapy. With that knowledge, I request and consent to receive therapy from qualified personnel of this agency. **Initials**_____

2. I understand that the staff of this agency may not disclose information about my therapy to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child senior, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow staff of this agency to provide some information about my therapy to a referring agency and/or an insurance company or other payer, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed. **Initials**_____

3. I understand that my therapist may work with me at this agency, in my home, or in other settings based on his/her professional judgment. I further understand that my therapy may involve my participation in individual, couple, family and/or group counseling, and may involve homework assignments for me to do outside of therapy sessions. I agree to participate actively in my therapy, to cooperate with my therapist, and to complete required homework assignments or other activities included in my therapy. **Initials** _____

4. I understand that if I participate in group counseling, a condition of my doing so is that I protect the privacy and confidentiality of other participants. I agree that if I participate in group counseling, I will not disclose information about the identity, words, or actions of other group counseling participants to anyone outside the therapy group. **Initials**_____

5. I understand that my therapy may include my attendance at meetings of independent self-help support groups including Alcoholics Anonymous, Narcotics Anonymous, and/or other programs. I agree to participate in such programs if assigned and to abide by the practices of those programs regarding protecting the privacy of anonymity of other program participants. **Initials** _____

6. I understand that my Clinical Substance Abuse Assessment for clients with a DWI offense is only valid for 6 months. If I have not begun services within 6 months of the completion of the Clinical Substance Abuse Assessment, a new SA assessment is required in order to ensure the inclusion of my current level of functioning, severity of identified problems and provision of appropriate level of care. I will be responsible for paying the cost of another assessment. **Initials** _____

_____

Client/Guardian's Signature Date

Consent for Emergency Care

Client Name:	Record #:
Medicaid #:	Date of Birth:

I consent to Emergency Medical Care: This is to authorize Waynesboro Family Clinic to seek emergency medical care if needed. It is understood and agreed that the staff and Waynesboro Family Clinic will be held harmless for any and all results of the staff's efforts to obtain emergency medical treatment including any accident or injury while being transported.
If emergency medical care is deemed necessary by the director of the program, and neither I nor any person named below can be reached, I authorize the person in charge to procure medical care and to act on my behalf in granting permission for the above named individual/client to receive treatment or surgery.

Guardian/Legally Responsible person's name:_____

Relationship: _____Business and Home Phone:_____

Where Employed:_____ Hours:_____

Guardian/Legally Responsible person's name:_____

Relationship: _____Business and Home Phone:_____

Where Employed:_____ Hours:_____

In case of emergency contact:

Name: _____Relationship:_____ Phone:_____

Name: _____Relationship:_____ Phone:_____

Emergency care information:

Physician:_____ Phone:_____

Hospital Preference:_____ Phone:_____

_____ _____
Consumer/Legally Responsible Person Date

_____ _____
Witness Date

Consumer Grievance Procedures

A. In the event an individual has a complaint regarding services received from WFC, they shall follow the plan below. Any consumer or guardian of a consumer has the right to file a grievance without interference or retaliation

B.

1. A written statement of the complaint shall be sent to the Clinic Administrator. A copy of the letter shall also be sent to the Clinical Director.
2. *The Clinical Administrator shall respond to the individual that made the written complaint within* twenty-four (24) hours of receiving the complaint.
3. If the individual is not satisfied with the response given by the Clinical Administrator, the letter of complaint shall be discussed with the Clinical Director.
4. The Clinical Director shall respond to the individual within twenty-four (24) hours of receiving the complaint.
5. If the individual is not satisfied with the response, he/she shall send the written complaint to review with the Community Advisory Board. All actions at this level are considered final.

C. A copy of the grievance procedure shall be given to any individual served by WFC.
D. An individual may contact the Governor's Advocacy Council at (919) 733-9250 or the Eastpointe LME.

WAYNESBORO FAMILY CLINIC, P.A.
Client Rights and Responsibilities

Each client receiving services from WFC, PA shall have the following rights.
*NOTE: Services provided are based on individual need.

1. To be fully informed, at the time of admission, of services available from WFC, PA and of any charges for services. This includes full information about client rights.
2. To participate in the development and future changes in his/her plan of care.
3. To be fully informed, in advance, of any changes in the services to be provided by WFC, PA.
4. To voice grievances about his care and not be subject to discrimination or reprisal for doing so.
5. To accept or refuse treatment to extend permitted by law and to be informed of the consequences of such refusal.
6. To be assured confidential treatment of personal and service records and to approve or refuse their release to any individual outside the agency.
7. To be treated with respect, consideration and full recognition and individuality, including privacy in treatment and in care for personal needs.
8. To be assured that they the personnel who provide care are qualified through education and experience, to carry out the services for which they are responsible.
9. To be notified of the services to be provided and the schedule of services.
10. To formulate advance directives that describe the clients desires relating to his medical care.
11. To be fully informed about any changes for services to be provided and about expected payments from other sources.
12. To be informed of the process for acceptance and continuance of service and eligibility determination.
13. To be informed of the agency's on call system. On call phone number (919) 580-5016.
14. To be informed of supervisory accessibility and availability.
15. To be advised of the agency's procedures for discharge.
16. To be free from abuse, neglect, mistreatment and unauthorized restraint.
17. To be free from performing services that do not qualify as training activities.
18. To be free from exclusion of ongoing programming as a result of inappropriate behavior.
19. To make and receive confidential telephone calls.
20. To participate in co-educational programs.
21. To be free from any loss of meal for programmatic or other reasons.
22. To receive the telephone number for the Governor's advocacy counsel which is (919) 581-1029.
23. To receive explanation of Client Rights in a manner consistent with comprehension.
24. To be assured of the right to dignity and human care in the provision of personal health, hygiene, and grooming.

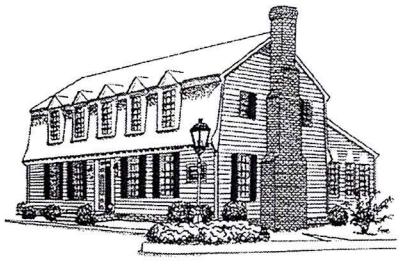
As a client of Waynesboro Family Clinic, P.A., you have the responsibility to:

1. Verify your insurance coverage and obtain any prior authorization. Failure to do so will result in a denial from the insurance company, and you will be responsible for any denied claims.
2. Provide accurate and complete information about your condition and needs as well as an accurate financial history regarding ability to pay for services.
3. Notify the agency of any changes in situation that will affect the agreed upon services you are receiving.
4. Notify WFC, P.A. at (919) 734-6676 of any problems, concerns or complaints with services. Unresolved complaints may be reported to the Division of Facility Services complaint hotline at (919) 733-6650.
5. Comply with the Personal Care Plan that was jointly developed.
6. Notify the agency of any advance directive or changes in these documents.
7. Request information and help resolve questions about care.
8. Provide and maintain a safe home environment.
9. Disability Rights of North Carolina. www.disabilityrightsnc.org 1-877-235-4210 TTY 1-888-268-5535

_____ _____
Consumer Name Date

_____
Consumer or Parent/guardian signature

_____ _____
Witness Date



Waynesboro Family Clinic, P.A.

Behavioral Medicine - Family Psychotherapy

1706 Wayne Memorial Drive • Goldsboro, NC 27534-2240
O: 919-734-6676 F: 919-734-9050

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

_____

Client/Guardian's Signature Date

NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGMENT OF NOTICE

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Waynesboro Family Clinic's Notice of Privacy Practices and Office Policies. I understand that if I have any questions regarding the Notice or my privacy rights I can contact Stacy Keel, Office Manager.

_____

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

_____

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

_____ Patient/client refuses to acknowledge receipt:

_____

Signature of Staff Member **Date**

WAYNESBORO FAMILY CLINIC, P.A.

Behavioral Medicine - Family Psychotherapy

1706 WAYNE MEMORIAL DRIVE • GOLDSBORO, N.C. 27534-2240 • (919) 734-6676

All IPRS (EASTPOINTE FUNDED) AND MEDICAID CLIENTS

MUST COMPLETE THIS FORM BEFORE YOU MEET WITH YOUR THERAPIST/PSYCHIATRIST TODAY. IPRS WILL NOT PAY FOR YOU R SERVICE TODAY WITHOUT THIS INFORMATION.

(**INFORMATION NEEDED FOR MEDICAID CLIENTS IN THE EVENT YOU LOSE MEDICAID AND WE NEED TO TRANSITION YOU OVER TO IPRS FUNDING)

Client Name: _____
(If client is a child please report parent income)

Date of Birth: _____

Family Size: _____
(If you are an adult client and live with your parents, grandparents, aunts/uncles, brothers/sisters you are a *family of 1 and won't include their income*)

Please complete all income sources that apply to you and/or your spouse (partner). Income includes total yearly monies before taxes.
Do not include food stamps or housing assistance.

_____: Your wage/salary

_____: Your spouse/partner's wage/salary

_____: Self-employment earnings

_____: Any retirement, unemployment, strike benefits, SSI, workman's comp., and any public assistance

_____: College or university scholarships, grants, fellowships and assistantships

_____: Dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

_____: Total income from above sources

Your signature Date signed

Thank you for your assistance,
Hillary Smith, Quality Assurance Director

OFFICE POLICIES & GENERAL INFORMATION

AGREEMENT FOR PSYCHOTHERAPY SERVICES

Waynesboro Family Clinic, P.A.

1706 Wayne Memorial Drive, Goldsboro, NC 27534

Phone: (919) 734-6676 Fax: (919) 734-9050

This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices.

Confidentiality: All information disclosed with in sessions and written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission except where disclosure is required by law. Most of the provisions, explaining when the law requires disclosure, were described to you in the Notice of Privacy Practices that you received with this form.

The Process of Therapy/Evaluation: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of specific concerns that lead you to seek therapy. Working towards these benefits, however, requires an effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Your therapist/doctor will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation.

During an evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, etc. Your therapist/doctor may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended.

Psychotherapy may result in decisions about changing behaviors, employment, substance use, relationships, etc. Sometimes another family member views a decision that is positive for one family member quite negatively. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, it is likely to draw on various psychological approaches accordingly or in part to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include behavioral, cognitive/behavioral, psycho dynamic, existential, system/family and developmental (adult, child, family), or psycho educational.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, your therapist/doctor will discuss with you (client), his/her working understanding of the problem, treatment plan, therapeutic objectives, and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of procedures used in the course of your therapy, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist/doctor does not provide, he/she has an ethical obligation to assist you in obtaining those treatments.

Dual Relationship: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs your therapist/doctors objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. Your therapist/doctor will assess carefully before entering into a non-sexual and non-exploitative dual relationship with clients. We are a small town, and many clients know each other and the therapist/doctor. Consequently, you may bump into someone you may know in the waiting room or you may bump into the therapist/doctor out in the community. Your therapist/doctor will never acknowledge working therapeutically with anyone without his/her written permission. Many clients choose their therapist/doctor because they know him/her before they enter into therapy with him/her and/or are aware of his/her stance on the topic. Nevertheless, your therapist/doctor will discuss with you, his/her clients, the often-existing complexities, potential benefits, and difficulties that may be involved in such a relationship. Dual or multiple relationships can enhance therapeutic effectiveness, but can also detract from it and often it is impossible to know that ahead of time.

It is your responsibility to communicate to the therapist/doctor if dual relationship becomes uncomfortable for you in any way. Your therapist/doctor will always listen carefully and respond accordingly to your feed back. Your therapist/doctor will discontinue the dual relationship if he/she finds it interfering with the effectiveness of the therapeutic process or the welfare of the client, and, of course, you can do the same at any time.

Consultation: Your therapist/doctor consults regularly with other professionals regarding his/her clients; however, the client's name or other identifying information is never mentioned. The client's identification remains completely anonymous, and confidentiality is fully maintained.

Considering all of the above exclusions, if it is still appropriate, upon your request, your therapist/doctor will release information to any agency/person you specify unless your therapist/doctor concludes that releasing such information might be harmful in any way.

Telephone & Emergency Procedures: If you need to contact your therapist/doctor between sessions, please leave a message with the front office and your call will be returned as soon as possible.

If an emergency situation arises, please indicate it clearly in your message. If your have a life-threatening emergency, go directly to the nearest emergency room.

Termination: As set forth above, after the first couple of meetings, your therapist/doctor will assess if he/she can be of benefit to you. Your therapist/doctor does not accept clients who, in his/her opinion, he/she cannot help. In such a case, he/she will give you a number of referrals that you can contact. If at any point during psychotherapy, your therapist/doctor assesses that he/she is not effective in helping you reach the therapeutic goals, he/she is obligated to discuss it with you and, if appropriate terminate treatment.

You also have the right to terminate therapy at any time. If you choose to do so, your therapist/doctor will offer to provide you with names of other qualified professionals whose service you might prefer. If you request in writing we will ensure that your records are transferred to the therapist/doctor of choice.

Mediation & Arbitration: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the therapist/doctor and client (s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any resolved controversy related to this agreement should be submitted to and settled by binding arbitration in Wayne County, in accordance with the rules of the American Arbitration Association which are in effect at the time demand for arbitration is filed. Notwithstanding, the foregoing, in the event that your account is overdue or unpaid and there is not agreement on a payment plan, the therapist/doctor can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration. the arbitrator will determine the sum.

Emergencies: If there is an emergency during our work together or in the future after termination, where your therapist/doctor becomes concerned about your personal safety, the possibility of you injuring someone else or about you receiving proper psychiatric care he/she will do whatever he/she can, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, he/she may also contact the person whose name you have provided on the biological sheet.
required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist or doctor. In couple and family therapy or when a different family member(s) are seen individually, confidentiality and privilege do not apply between couples or among family members. Your therapist/doctor will use his/her clinical judgment when revealing such information. Your therapist /doctor will not release records to any outside party unless he/she is authorized to do so by all adult family members who were part of the treatment.

When Disclosure is Required by Law: Some of the circumstances where disclosure is required by law are: where there is reasonable suspicion of child, dependent or elder abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely unstable (for more details see Notice of Privacy Practices).

Heath Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/or EAP in order to process the claims. If you instruct your therapist/doctor, only the minimum necessary information is to be communicated to the carrier. Unless authorized by you explicitly, the Psychotherapy Notes (also known as progress notes, which therapist in this clinic generally do NOT keep) will not be disclosed to your insurance carrier.

Your therapist/doctor has no control or knowledge over what insurance companies do with the information he/she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to the future eligibility to obtain health or life insurance. Accessibility to companies' computers or the Nation Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen or accessed by enforcement agencies: therefore, you are in a vulnerable position.

Confidentiality of E-Mail, Cell Phones and Fax Communication: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your therapist/doctor at the beginning of treatment if you decide to avoid or limit, in any way, the use of any or all of the above mentioned communication devices. Please do not use e-mail or faxes for emergencies.

Payment & Insurance Reimbursement: Clients are expected to pay the standard hourly office fee per session at the time of check-in unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify the front office if any problem arises during the course of therapy regarding your ability to make timely payment. Clients who carry insurance should remember that professional services are rendered and charged to clients and not to the insurance companies. Unless agreed upon differently, your therapist/doctor will file your insurance for you. As indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Insurance companies do not reimburse for all issues/conditions/problems which are the focus of psychotherapy. It is **your responsibility** to verify the specifics of your coverage.

It is the responsibility of the patient/guardian to obtain any prior authorization, if needed. Failure to do so will make you responsible for the full amount billed. Patient/guardian is also responsible for paying for co-pays, deductibles, and any service the insurance company does not cover.

Cancellation: Since scheduling an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. **There will be a fee charges for sessions missed without such notification. Insurance companies do not reimburse for missed sessions.**