



CLIENT INFORMATION FORM

Today's Date: _____

Client's Name: _____ DOB: _____

Home Street Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

If the client is a minor or an adult with a legal guardian, please provide the following information about the parent or legal guardian:

Parent/Guardian's name: _____ DOB: _____

Home street address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Preferred way to contact you: _____

Emergency Contact: _____ Phone: _____

Address: _____

If we have to contact you, we will be discreet. However, are there any restrictions we should know about calling you? (For example: please do not call at work, please do not leave messages): _____

Personal and cultural information: We want to provide services that respect your personal and cultural background. Providing the following information can help us to do that. This information, however, is optional. We will not deny you services if you choose to omit this information. If you have any questions about this, please ask.

Race/Ethnicity: _____ **Religion/Faith:** _____
Country of Birth: _____
Sexual Orientation: _____ **Marital Status:** _____
Gender Identity: _____ **Preferred pronouns:** he/his she/her they/their other

How comfortable are you communicating in English? Completely A little Not at all

How comfortable are you reading in English? Completely A little Not at all

Our staff communicates in English. Will you need an interpreter? Yes No

Insurance Information: Please provide as much information as you have.

Insurance Provider: _____ **Effective Date of Coverage:** _____
Identification/policy # _____ **Group or Enrollment #** _____
Name of Policy Holder: _____ **Policy Holder's DOB:** _____

Is there another (secondary) insurance policy? If so, please provide as much information as you have.

Insurance Provider: _____ **Effective Date of Coverage:** _____
Identification/policy # _____ **Group or Enrollment #** _____
Name of Policy Holder: _____ **Policy Holder's DOB:** _____

I authorize the release of any medical or other information necessary to process claims submitted to the named insurer. I authorize payment of health insurance benefits to Behavioral Health Solutions, PA for services furnished to me or to the client named above.

Client's Name Signature of Client Date

Name of Parent/Legal Guardian Signature of Parent/Legal Guardian Date

Sexual Behavior Treatment Program Intake Evaluation Procedures, Risks and Benefits, and Limits to Confidentiality

You have been referred to our Sexual Behavior Treatment Program. The first step of treatment is this Intake Evaluation. The purpose of the Intake Evaluation is for us to learn about the reasons you were referred for treatment and to begin to determine your individual treatment needs. It is also an opportunity for you to ask questions about this treatment program.

Evaluation Procedures

This intake evaluation will involve an interview, one or more psychological tests, and a review of certain background records or materials.

About Our Appointments

We take our appointments with you very seriously. Please make every effort to keep your appointments with us. If you are unable to keep an appointment, please contact us to let us know. If we are unable to keep a scheduled appointment, we will contact you as soon as possible to let you know. Please let us know about changes in your contact information so we can contact you if necessary.

If you arrive more than 10 minutes late without advance notice, we may have to reschedule your appointment and consider the session to be a "No Show."

Fees, Payments, & Billing

We charge \$250.00 for this intake evaluation. This fee covers charges for the interview, record review, test scoring and interpretation, and writing the report.

If you have a health insurance policy, it may provide some coverage for mental health treatment. It is important that we find out exactly what mental health services your insurance policy covers. Always remember that you (and not your insurance company) are responsible for full payment of charges.

Cancellation and No Show Policy

If you must cancel an appointment, please notify us at least 24 hours in advance. You will be charged a late cancellation fee of \$85.00 if you cancel an appointment with less than 24 hours' notice. Similarly, you will be charged \$85.00 if you do not keep an appointment at all. The late cancellation/no show fee will be your responsibility, and it must be paid in full before your next appointment. If you have 3 or more "No Shows" or "Late Cancellations," we have the option to suspend or terminate your treatment.

Culturally appropriate services

We appreciate that a person's culture and background can affect mental health services. We are dedicated to providing effective services that respect our clients' cultural and personal backgrounds. Please let us know what aspects of your cultural and personal background are important to you, so we can best work with you.

Language Appropriate services

Clear communication is a necessary part of the services we provide. Our psychotherapists and administrative staff communicate in English. If you, the client, or people who are necessary to the client's mental health services do not feel comfortable communicating in English, let us know. If necessary, we will arrange for interpretive services. Psychotherapy usually cannot be conducted through an interpreter. However, an interpreter may be necessary to communicate with other people involved in a client's care (such as a parent who provides consent for treatment).

Sexual Behavior Treatment Program Intake Evaluation (continued)

Drugs & Alcohol Policy

Clients (and people who come with clients, such as friends or family members) must be sober when they are in our office. Anyone who appears to be under the influence of drugs or alcohol when they arrive for an appointment will be asked to leave. A client who is asked to leave for this reason will be considered a “No Show” (and charged the \$85.00 no show fee).

Children

Children under the age of 16 must be supervised by a responsible adult at all times. This includes when they use the coffee machine and restroom. We do not provide supervision. Minors who can drive themselves are expected to act appropriately.

Animals

Service animals and well-behaved emotional support animals are permitted in our office. Animals you bring with you must be in your control at all times. Although we love animals, not everyone who visits our office feels the same way.

Medical Emergencies while at our office

If you experience a medical emergency while at our office, we must seek emergency treatment on your behalf.

Cell Phones

Please have your electronic devices on silent, and take phone calls outside. It helps to provide a quiet and peaceful environment for everyone.

About Confidentiality

We take confidentiality very seriously. In most situations, we will need written permission from you (an Authorization to Release Information) to share your personal information with other people. However, there are also limits to doctor – patient confidentiality, and in some situations we will have to share information with other people, even without your permission. These situations are: suspicion of child neglect or abuse; suspicion of neglect or abuse of a disabled adult; an appropriate court order; likely dangerous behavior to self or others; likely commission of a felony or violent misdemeanor; and the need for emergency medical treatment. In the event that any of these become an issue, we may share some confidential information about you with others.

All of our clients expect confidentiality. Please do not disclose the name or identity of any other client being seen in this office.

We retain the records of adult clients for 12 years after the end of services. During that time, we will keep records in a safe place. After 12 years, we will destroy those records. If the client is a minor, we will keep the records for 12 years after the end of services or until the client turns 30, whichever is longer.

If we must stop providing services (for example, if our practice closes due to illness), we will transfer your records to another mental health professional who will also keep them confidential and protected.

Sexual Behavior Treatment Program Intake Evaluation (continued)

As noted in the **Notice of Privacy Practices**, you can review your own records at any time. However, you may not examine records we have received from an outside source. You will need to contact the original source of those records.

An insurance company will sometimes ask for additional information about symptoms, diagnosis, and treatment methods before it will pay for services. We will let you know if this should occur and what information the company has requested. Please understand that we have no control over how insurance companies handle this information. We provide only as much information as the insurance company requires to pay your benefits.

Other Points

If you ever become involved in a divorce or custody dispute, we will **not** provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you may require. This position is based on two reasons: (1) Our statements will be seen as biased in your favor because we have a therapeutic relationship; and (2) the testimony might affect our therapeutic relationship, and we must put the therapeutic relationship first.

Emergency Procedures

If an urgent situation arises and you cannot reach your psychotherapist quickly, please make use of the local Emergency services in your community. Some important emergency services are listed below:

UNC Hospital Emergency Room	984-974-4721	Police/Sheriff/Rescue	911
Duke Hospital Emergency Room	919-684-2413		

Complaint Procedures

Problems can arise in your relationship with a mental health treatment provider, just as in any other relationship. If you are not satisfied with any area of our work, please let your psychotherapist know at once. Your work together will be slower and harder if your concerns are not addressed. We will make every effort to hear your complaints and to seek solutions to them in a timely manner. Some complaints can be addressed quickly, and other complaints may take longer to resolve. When we discuss your complaint with you, we will give you an estimate of how long we may need to address your complaint.

Our practice does not discriminate against clients because of age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, gender identity, or criminal record unrelated to present dangerousness. We will always try to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please tell us immediately.

If you are dissatisfied with our response to your grievance/complaint (or if you do not feel comfortable filing a grievance/complaint directly with us), you have the right to file a grievance/complaint with companies and agencies outside of Behavioral Health Solutions.

Sexual Behavior Treatment Program Intake Evaluation (continued)

For **Blue Cross Blue Shield** members:

Call **BCBSNC Customer Service** at 1-888-206-4697

For **CIGNA** members:

Call **CIGNA Customer Service** at 1-800-997-1654

For **United Healthcare** Members:

Call **United Healthcare Customer Service** at 1-800-444-6222

For **AETNA** members:

Call **AETNA Customer Service** at 1-800-872-3862

If you believe a treatment provider at Behavioral Health Solutions has acted unethically, you have the right to file a complaint with the relevant licensing board. Psychologists in North Carolina are licensed by the **North Carolina Psychology Board**. Social workers in North Carolina are licensed by the **North Carolina Social Work Certification and Licensure Board**. Licensed Professional Counselors in North Carolina are licensed by the **North Carolina Board of Licensed Professional Counselors**.

To file a complaint with the **North Carolina Psychology Board**:

- Complete a Complaint/Inquiry Form at www.ncpsychologyboard.org/complaints/
- You may call the Psychology Board at 1-828-262-2258 for more information.

To file a complaint with the **North Carolina Social Work Certification & Licensure Board**:

- See www.ncswboard.gov/complaint-disciplinary-process/
- You may call the Social Work Board at call 1-800-550-7009 for more information.

To file a complaint with the **North Carolina Board of Licensed Professional Counselors**:

- See www.ncblpc.org/complaints for more information
- Call the Board at 844-622-3572 or 336-217-6007

Clients with disabilities may also contact **Disability Rights North Carolina** at:

- 1-877-235-4210 or 919-856-2195.
- The mailing address is 2626 Glenwood Avenue, Ste. 550, Raleigh, NC 27608
- The website is www.disabilityrightsnc.org.

Consent for Evaluation

I have read, or have had read to me, the information in this document. I have discussed those points I did not understand, and I have had any questions answered fully.

I hereby agree to participate in this evaluation. I agree to the terms described in this document. I understand that I have the right to refuse participation in this evaluation, and that I have the right to end my participation at any time.

Client's name

Signature of client (or person acting for client)

Date

Printed Name if different from client

Relationship to client

☐ Self ☐ Parent ☐ Legal Guardian

Coordination of Care Record

Client's Name: _____ DOB: _____

Date of admission to services: _____ Therapist: _____

Do you have a primary care provider? Yes No	Name of primary care provider: _____ Address: _____ Phone, fax, email: _____
Do you have a psychiatrist? Yes No	Name of psychiatrist: _____ Address: _____ Phone, fax, email: _____
Do you have an attorney or case worker? Yes No	Name of attorney or case worker: _____ Address: _____ Phone, fax, email: _____
Do you have a probation officer? Yes No	Name of probation officer: _____ Address: _____ Phone, fax, email: _____

Please list any medications you are taking

Prescription Name	Dosage	# Times Day	Date Started	Prescribed by

Notice of Privacy Practices

This notice describes how mental health and medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

SUMMARY

Your Rights (see pages 10 and 11)

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices (see page 11)

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide mental health care
- Provide disaster relief

Our Uses and Disclosures (see pages 11 and 12)

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Notice of Privacy Practices (continued)

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your record**
 - You can ask to see or get an electronic or paper copy of your record and other health information we have about you. Ask us how to do this.
 - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record**
 - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
 - We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- **Request confidential communications**
 - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
 - We will say “yes” to all reasonable requests.
- **Ask us to limit what we use or share**
 - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
 - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
- **Get a list of those with whom we’ve shared information**
 - You can ask for a list of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
 - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice**
 - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you**
 - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
 - We will make sure the person has this authority and can act for you before we take any action.

Notice of Privacy Practices (continued)

- **File a complaint if you feel your rights are violated**
 - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
 - We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

- **Treat you**
 - We can use your health information and share it with other professionals who are treating you. *(Example: A psychiatrist treating you asks us for our thoughts and observations about your condition.)*
- **Run our organization**
 - We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- **Bill for your services**
 - We can use and share your health information to bill and get payment from health plans or other entities. *(Example: We give information about you to your health insurance plan so it will pay for your services.)*
- **Help with public health and safety issues**
 - Reporting suspected abuse or neglect
 - Preventing or reducing a serious threat to anyone's health or safety
 - Preventing disease
 - Reporting adverse reactions to medications

Notice of Privacy Practices (continued)

- **Comply with the law**
 - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law
- **Work with a medical examiner or funeral director**
 - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests**
 - For workers' compensation claims
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions**
 - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice will go into effect on November 19, 2014.

For questions or concerns, contact Keith Hersh, PhD at 919-419-0524 or khersh@bhspa.net.

**Notice of Privacy Practice
Acknowledgement of Receipt Form**

I have read, or have had read to me, the Notice of Privacy Practices. I have discussed anything that I did not understand, and I have had my questions answered fully.

Patient or Representative's Signature

Date

Printed Name

If the acknowledgement is signed by a representative for the patient, the name of the patient and a description of such representative's authority to act for the patient must be provided.

Patient's Name

Authority to act for patient (example: parent or legal guardian)