



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

## **Psychological Evaluation**

### **Procedures, Risks and Benefits, and Limits to Confidentiality**

You have been referred to us for a psychological evaluation. These evaluations are conducted when a third party wants an independent assessment of your psychological functioning. This type of evaluation may be requested by attorneys, judges, probation officers, caseworkers with social services, or other people.

#### **Evaluation Procedures**

Typically, a psychological evaluation consists of one or more personal interviews, a number of psychological tests, and a review of certain background records or materials.

#### **About Our Appointments**

We take our appointments with you very seriously. We ask that you 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. It is your responsibility to keep your contact information current.

#### **Fees**

We charge \$200.00 per hour for interviews, individualized testing, and record reviews. We also charge \$200.00 per hour for preparation of reports and other significant documentation. We do not charge for the time that it takes you to independently complete psychological tests at our office. However, some tests may have scoring fees charged by the test developer, and these scoring fees must be paid by you.

Clients receiving psychological evaluations are required to pay the full cost of the evaluation. Typically, a deposit will be requested from you before the evaluation begins. If this deposit does not cover the full cost of the evaluation, we will notify you of the additional cost. We reserve the right to withhold communication of a verbal opinion and/or sending the final report until all charges are paid. If we do not use the entire deposit, we will return the unused portion to you. You can contact us when all services have been provided to inquire whether any of the deposit remains unused.

We do not file claims to insurance companies for psychological evaluations. However, we can provide you with a statement of services that you can submit to your insurance company to see if it will reimburse you for any of the expenses.

#### **Risks and Benefits**

You should know about the risks and benefits of psychological evaluation so that you may make an informed decision to participate in the evaluation process. Known benefits of psychological evaluations are: information to the client, the referral source, the treating professional, and/or others as authorized by the client; increased documentation or understanding of certain psychological issues. Known risks of psychological evaluation are: emotional discomfort in being interviewed or tested; and disagreement with evaluation results.

#### **Culturally appropriate services**

We appreciate the impact of a person's culture and background on mental health services. We are dedicated to providing effective and equitable services that respect our clients' cultural and personal backgrounds. Please let us know the aspects of your cultural and personal background that are important to you and which we should understand to best work with you.

## Psychological Evaluation (continued)

### **Language Appropriate services**

We appreciate the importance of communicating clearly with our clients and the importance of our clients understanding the services we provide. We communicate in English. If you, the client, or people who are necessary to the client's evaluation do not feel comfortable communicating in English, let us know. If necessary, we will arrange for interpretive services.

### **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.

When you have been referred for evaluation by a third party, you will be asked to sign an authorization to release information about the evaluation to the referring party.

In North Carolina, records of persons who are referred by their attorneys are protected under the attorney – client privilege (except in Workers Compensation cases). If we are asked to prepare a report or testify in a legal manner by the referring attorney, the client gives up the privilege of confidentiality at that time. In North Carolina, records of persons who are court ordered to undergo psychological evaluation are not confidential, and results will be made known to the Court.

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.

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.

### **Drugs & Alcohol Policy**

Clients (and people with clients, such as friends or family members) must be sober when in our office. Clients or other people who appear 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.”

## Psychological Evaluation (continued)

### **Children**

Children under the age of 16 must be supervised by a responsible adult at all times. We do not provide supervision. This includes when they use the coffee machine and restroom. 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 brought 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 are obligated by law to seek emergency treatment on your behalf.

### **Cell Phones**

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

### **Complaint Procedures**

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 take steps 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 bring the matter to our attention 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 agencies outside of Behavioral Health Solutions. We will not retaliate against you for filing a complaint.

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/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).

If you believe a licensed psychologist at Behavioral Health Solutions has acted unethically, you have the right to file a complaint with the **North Carolina Psychology Board**.

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

- Complete a Complaint/Inquiry Form at [www.ncpsychologyboard.org](http://www.ncpsychologyboard.org)
- You may call the Psychology Board at 1-828-262-2258 for more information.

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](http://www.disabilityrightsnc.org).

## Consent for Evaluation

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: \_\_\_\_\_

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

**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 9 and 10)**

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 10)**

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 10 and 11)**

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/](http://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](mailto: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)