PORTERS NECK COUNSELING NEW PATIENT WELCOME PACKET

Please provide us with the following information

DATE ________________ TIME ________________ REFERRAL SOURCE ____________________

PATIENT NAME ________________________________ DOB ____________ AGE ____________

MARITAL STATUS ______________________ SEX ____________ RACE ___________

ADDRESS ____

HOME PHONE ____________________ WORK PHONE ________________ CELL ____________

EMAIL: ____________________

MAY A VOICE MESSAGE BE LEFT AT ANY OF THE ABOVE NUMBERS?_______ SPECIFY WHICH_______

EMERGENCY CONTACT ______________________________ PHONE ____________________________

CURRENT EMPLOYER OR SCHOOL ____

WHAT PROBLEM(S) BROUGHT YOU IN TODAY? ____

____

ARE YOU SEEKING SERVICES? VOLUNTARY:_______ INVOLUNTARY: _______

WORK ORDERED: _______ COURT/LEGAL MATTER REQUIRED: _______

PLEASE RATE THE SEVERITY OF YOU PROBLEMS BY CIRCLING A NUMBER ON THE FOLLOWING SCALE:

0	1	2	3	4	5	6	7	8	9	10
No Discomfort				Moderate Discomfort						Extreme Discomfort

LIST HISTORY OF MEDICAL CONDITIONS/ILLNESSES/SURGERIES:

__________________________ __________________________ __________________________

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING VITAMIN/MINERAL SUPPLEMENTS:

____

____

PLEASE LIST ALL CURRENT ALLERGIES, INCLUDING FOOD ALLERGIES:

____

____

PRIMARY PHSCIAN: ____
(Your physician will not be contacted without your consent)

DATE OF LAST PHYSICIAN EXAMINATION: ____

NUMBER OF PERSONS LIVING IN YOUR CURRENT HOUSEHOLD: ____________________________

NUMBER OF CHILDREN: ______________________ AGE(S) OF YOUR CHILDREN: ______________

WOULD YOU DESCRIBE YOUR CURRENT MARITAL/SIGNIFICANT RELATIONSHIP AS (circle one):

Poor Fair Good Very Good Excellent

ARE YOU CURRENTLY EXPERIENCING FINANCIAL DISTRESS: NO YES

ARE YOU EXPERIENCING LEGAL PROBLEMS? If yes, please explain ______________________________

____

EDUCATION COMPLETED______________________ DEGREE ______________________

HAVE YOU EXPERIENCED ANY ABUSE? NO YES (indicate type(s) below)

______Sexual ______Neglect ______Verbal

______Physical ______Spiritual ______Emotional

PLEASE CHECK ALL OF THE BELOW THAT YOU CURRENTLY USE AND INDICATE QUANTITY:

- Cigarettes/tobacco ______________________
- Alcohol ______________________
- Coffee ______________________
- Marijuana ______________________
- Cocaine ______________________
- Other drugs ______________________

DOES ANYONE IN YOUR CURRENT HOUSEHOLD, OR IN YOUR FAMILY OF ORIGIN, HAVE ALCOHOLISM OR OTHER SUBSTANCE ABUSE PROBLEMS? NO YES (Please explain below)

____

HAVE YOU EVER PREVIOUSLY RECEIEVED COUNSELING/MENTAL HEALTH SERVICES? NO YES

Problem addressed ____

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC TREATMENT? NO YES
If "yes," please list dates/hospitals where treatment was provided: ______________________

____

HAVE YOU EVER ATTEMPTED SUICIDE? NO YES
If "yes," please list number of times, when, and method: ______________________________

____

ARE YOU CURRENTLY EXPERIENCING ANY THOUGHTS OF SUICIDE? NO YES
If "yes," do you have a plan? Please describe: ______________________________________

____

ARE YOU CURRENTLY EXPERIENCING ANY THOUGHTS OF HARMING SOMEONE ELSE? NO YES
If "yes," do you have a plan? Please describe: ______________________________________

____

DOES ANYONE IN YOU FAMILY HAVE A HISTORY OF MENTAL ILLNESS? NO YES
If "yes," can you please provide brief details? ______________________________________

Office Policies

Appointments and Cancellation Policy
Our goal is to provide quality care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. This policy enables us to better utilize available appointments for our clients in need of care.

Scheduling of an Appointment
To schedule a new appointment please call (910) 686-3505. The receptionist will email, advise how, and/or make arrangements for you to receive our new patient intake paperwork packet. The paperwork should be filled out and completed in its entirety then returned to the receptionist for review. Please include your photo ID and a copy of your insurance cards. Once the paperwork is received, reviewed, and processed new patients will be contacted by phone to schedule their first initial appointment with our office. Please be aware that all medication management patients will be required to submit a urinalysis drug screening at the time of their new patient appointment. Additionally, patients who are receiving ongoing controlled substance treatment will be subject to random urinalysis drug screenings and will be required to attend at least two individual counseling sessions per month provided by this office.

Cancellation Policy
Please be courteous and call the above number promptly if you are unable to attend an appointment. Except in the case of emergency, a 48-hour (business hour) advance notice is required this will allow this time to be reallocated to someone in urgent need of treatment. This is how we can best serve the needs of our clients. All appointments must be confirmed and paid by 12 pm the business day prior to the scheduled appointment otherwise the appointment will be cancelled and will need to be rescheduled for a later date and once payment for service has been received. PNC now requires patients to sign our credit card payment authorization form, by doing this, you are authorizing payments for services and assured that you have a standing confirmation for future scheduled appointments.

We reserve the right to bill for an appointment not cancelled within the 48-hour (Business Hour) time frame at the rate of $50 per appointment. Please note, this includes if our office must cancel your appointment because you failed to confirm the appointment with our office by 12pm the day before and/or if you have not made payment for you scheduled appointment with our office by 12pm the day before.

How to Cancel Your Appointment
To cancel appointments please call (910) 686.3505 or you may cancel your appointment online via the patient portal. If you do not reach someone via phone, you may leave a detailed message on voice mail. You may not cancel via email. We reserve the right to bill for an appointment not cancelled within the 48-hour (Business Hour) time frame at the rate of $50 per appointment.

No Show Policy
A "no show" is someone who misses an appointment without canceling it in advance and within the allotted time frame. No-shows inconvenience those individuals who need quick access to an appointment and are on a waiting list.

A failure to present at the time of a scheduled appointment will be recorded in the clients' chart as a "no-show". Three consecutive "no-shows" will result in termination of care and referral to another service provider. We reserve the right to bill a "no-show fee" at the rate of $50 per missed appointment.

Professional Fees for Provider Phone/Email Communications
Clients who need to get in touch with their physician after hours will be asked to leave a detailed message on the voicemail stating their name, DOB, call back number and a brief message regarding the reason for their call. Return calls, emails, etc. services from a rendering provider outside of an appointment will be subject to Professional Fees as follows: $25 for 15 minutes or less, $50 for more than 15 minutes. These fees will be at the discretion of the provider.

We will make every effort to return your phone messages as soon as possible within the same day. However, **PLEASE NOTE: we DO NOT offer emergency services.** In the event of a life-threatening emergency – i.e. suicidal/homicidal ideations patients will need to call 911 or go to the nearest Emergency Room. We are happy to receive your calls and to assist you with some emergency/crisis situations as we are able to but our office is not open 24 hours a day or on weekends or for after hours. Discussions regarding non-emergency treatment issues should be reserved as able for the counseling session.

Early Refill Fees:
Request for prescription refills outside of a scheduled appointment will be subject to the following Professional fees: $25 for non-controlled substance medication, $50 for controlled substance medication.

Fees and Medical Records/Paperwork Requests
Please note, Porters Neck Counseling does not provide Workers Compensation documentation/paperwork, disability documentation/paperwork, nor do we provide DUI and/or court ordered appointments or legal documentation

Payment in full for appointments and other professional fees is due by 12pm the day before services is scheduled to be provided. This includes any co-pay, deductible, coinsurance, or self-pay fees for services. Please note, there will be a $50 NSF will be charged for any declined payments.

Early Refill Fees:
Request for prescription refills outside of a scheduled appointment will be subject to the following Professional fees: $25 for non-controlled substance medication, $50 for controlled substance medication.

A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing of medical records to the patient or the patient's designated representative. Inclusive of searching, handling, copying, and mailing costs: Administrative fee of $50.00 then:
$.75 for first 25 pages
$.50 for pages 26-100
$.25 for pages over 100
Minimum fee of $50.00 permitted
Medical records will be sent from out office one time only with a fax confirmation verifying the faxes transmission. A duplicate copy of the patients transmitted medical record will be provided to the patient at the patients request for further transmissions should they be required. PLEASE NOTE, PROVIDERS RESERVE THE RIGHT TO REFUSE ANY REQUESTED DOUMENTATION/LETTERS/PAPERWORK/ETC.

Should you require testimony or report in a civil, criminal or any other legal matter, that fee shall be $220.00 per sixty-minute hour. This charge will be for all services including, but not limited to: attorney consultation, document review, court testimony, wait-time in court, case correspondence, travel time and all other services relating to this activity. Should testimony or a report be needed payment of the equivalent of a one-day retainer ($1500.00) will be required. Should a scheduled trial appearance be cancelled with less than seventy-two hours' notice the retainer will be non-refundable.
PLEASE SIGN BELOW TO CONFIRM THAT YOU HAVE READ AND UNDERSTAND THE ABOVE POLICIES. PLEASE DISCUSS ANY QUESTIONS OR CONCERNS WITH YOUR PROVIDER. THANK YOU.

SIGNATURE ______________ DATE ______________

CONSENT FOR SERVICES:

By signing below, I consent to receive evaluation, diagnostic, and treatment services via telehealth. Should I decide to enter into treatment/counseling; a personalized treatment plan will be designed for me, with my input. This treatment plan will be subject to my approval and will be authorized by my signature. I understand that this is voluntary treatment, and that I have the right to withdrawal from treatment at any time.

Client Signature ________________ Date ______________

Clinician Signature ______________ Date ______________

NOTICE OF PRIVACY PRACTICES

A "Notice of Privacy Practices" that describes how your private health information is handled by this office has been provided with your intake packet.

(Please take a moment to review this and note any questions that you may wish to discuss. Please check one of the following boxes to verify your receipt (or non-receipt) of the "Notice of Privacy Practices." Thank you.)

☐ Yes, I have been given a "Notice of Privacy Practices" that informs me as to how my private health Information is handled and communicated by this practice, and also provides me with information regarding filing a complaint should I feel that my private health information has been used incorrectly.

☐ No, I have not been given a "Notice of Privacy Practices."

________________________________ ________________

Client Signature Date

CONSENT TO RECEIVE ELECTRONIC COMMUNICATIONS/TEXT MESSAGES/SERVICES

Due to the coronavirus pandemic Porters Neck Counseling is only offering telehealth appointments via UPDOX through our Electronic Health Records system. These appointments are conducted via a video teleconference method. Since these services are delivered electronically all patients will need to consent to receiving electronic services, messages, and communications. Additionally, we can now send you appointment reminders messages by email and text message. If you consent to receive these electronic forms of communications and messaging, please read the disclaimer and sign below.

____I consent to Porters Neck Counseling contacting me electronically by email or text message for the purpose of appointment reminders and confirmations.

____I consent to receiving treatment and services electronically.

____I understand that I may send electronic appointment confirmations back confirming my scheduled appointment and my credit card on file will be charged for my appointment.

I acknowledge that appointment reminders by email and text are an additional service and that these may not take place on all occasions, and that the responsibility of confirming, attending appointments or cancelling them still rests with me. I am aware I can confirm or cancel my appointments electronically. Other helpful features offered to you through our EHR system, include patient portal access and patient/provider direct messaging, and access to your patient health record which allows patients direct access to their patient profile enabling updates and/or changes to be made in patient charting including demographics and insurance information.

Email and text messages are generated using a facility. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

Please note we use this information strictly for the purposes of communicating with you more efficiently from our EHR. Our goal is to provide you with excellent treatment as well as overall service and satisfaction. We may disclose patient health information (PHI) to third parties only that perform services for this practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreement to protect the confidentiality of your PHI. Please be aware that our affiliates do not sell, share or rent our users' personally identifiable information, unless required by law. Also, they do not send any emails or other communications without your permission and they do not send out spam.

I agree to advise the practice if my email or mobile number changes or if this is no longer in my possession.

Name: ______________________________ Date of Birth: ______________

Mobile Number: ________________ Email: __________________________

Signed________________________ Date__________________________

CURRENT SYMPTOMS/PROBLEMS (CHECK ALL THAT APPLY):

Emotional symptoms

__ anger __ depression __ anxiety __ extreme mood shifts

__ irritability __ worry __ frustration __ helplessness

__ hopelessness __ fear __ apathy __ lack of emotions

__ guilt __ other (specify) ______________________________

Notes (for counselor's use):

Mental symptoms

__ problems with concentration __ inattention __ memory problems

__ difficulty making decisions __ distractibility __ racing thoughts

__ repeated unwanted thoughts __ other (specify) ______________________

Notes (for counselor's use):

Physical symptoms:

__ increase or decrease in appetite __ sleeps difficulties __ muscle tension

__ tearfulness/crying spells __ increased heart rate/pounding heart __ sweating/chills

__ stomach or intestinal distress __ frequent or severe headaches __ body pain/numbness

__ other (specify): ____

Notes (for counselor's use):

Behavioral symptoms:

__ hyperactivity __ impulsivity __ binge eating/overeating __ suicidal gesture/attempt

__ induced vomiting __ withdrawal __ arguing __ increased alcohol use

__ fighting/aggression __ disorganized __ oppositional/defiant __ self-injury

__ lying/deceitfulness __ avoidance of school or job

__ other (specify) ____

Notes for counselor:

CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, or other professional charges that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

PATIENT'S NAME: ______________________ AMEX/DISC/MC/VISA CARD # ______________________

NAME, AS IT APPEARS ON CREDIT CARD: ______________________ EXPIRATION DATE: ______/_______

BILLING ADDRESS: ______________________ BILLING ZIP CODE: __________

______________________ VERIFICATION CODE 3 or 4 DIGITS: ____________

EMAIL ADDRESS: ______________________

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize Porters Neck Counseling to charge the above credit card account for my appointments and professional services including any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. Additionally, I authorize Porters Neck Counseling to bill the above credit card when I do not give advanced notice for a late (less than 48 business hours) cancellation or no-show, as per my client agreement. Your credit card information will be kept on file and ran the day before your scheduled appointment whether it be a Telehealth or In Office appointment. If the credit card charge is declined and our office is not able to reach you by phone your appointment will be canceled and need to be rescheduled for a later date. Additionally, all credit card charges declined will be accessed an NSF fee of $50 and no further appointments will be scheduled until all outstanding balances have been paid in full. I waive any and all rights to cause a charge-back (i.e., a disputed, reversed, or contested charge) against these transaction for any reason. I agree to call and notify the receptionist in advance before my next scheduled appointment should any of my information change such as address, phone number, insurance, credit card information, and/or responsible party has changed.

I hereby authorize Porters Neck Counseling to charge my credit card for professional services rendered to me or the patient whose name appears above (and for appointments missed or cancelled with less than a 48-hour notice). By signing below, I am authorizing Porters Neck Counseling to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this form and can authorize charges to this card.

______________________ ______________

Cardholder Signature Date

INSURANCE INFORMATION:

CLIENTS NAME: ______________________ BIRTHDATE: ______________________

PRIMARY INSURANCE: ______________________ SOCIAL SECURITY NUMER: ______________________

INSURANCE ID: ______________________ GROUP/POLICY: ______________________

SECONDARY INSURANCE: ______________________

ADDRESS: ______________________

CITY/STATE: ______________________ ZIP: ______________________

MARITAL STATUS: ______________________ EMPLOYER: ______________________

HOME PHONE: ______________________ OTHER PHONE: ______________________

PATIENTS RELATIONSHIP TO INSURED: ______________________

INSURED NAME (if different than patient): ______________________ INSURED SSN: ______________________

SEX: M / F Date of Birth: ___/___/____ PHONE: ______________________

INSURED ADDRESS: ______________________

CITY/STATE: ______________________ ZIP: ______________________

PLEASE PROVIDE INSURANCE CARD SO THAT WE MAY COPY FOR OR RECORDS

I give this office permission to release any information obtained during evaluations or treatment of this client necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I understand that I am responsible for all charges, regardless of insurance coverage.

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the provider who provided service. Medicare/Medicaid regulations may apply. A photocopy of this assignment is to be considered as good as the original.

______________________ ______________

Client's (or parent/guardian's) Signature Date

Porters Neck Counseling, LLC

8044 Market Street Unit D Wilmington, NC 28411 Phone: 910.686.3505 Fax: 910.821.5116

PATIENT MEDICATION/ CONTROLLED SUBSTANCE TREATMENT CONTRACT

Patient Name: ________________________________ Date: ________________________

As a participant in medication management treatment at Porters Neck Counseling, I freely and voluntarily agree to accept this treatment contract as outlined below. Please initial each line item below, agreeing to the terms outlined in this treatment policy.

1. _______I agree to keep, and be on time to, all my scheduled appointments.
2. _______I agree to adhere to the payment policy outlined by this office.
3. _______I agree to conduct myself in a courteous manner while in the office.
4. _______I agree to pay all office fees for treatment by 12pm the business day before my scheduled appointment. I understand that failing to do so will result in the cancellation of my scheduled appointment & I therefore would need to reschedule my appointment for a later date once payment for services has been received & processed by the front office. I will be given a receipt as proof of payment that I can use for reimbursement from my insurance company.
5. _______I understand and agree that any missed appointment will result in a fifty ($50) cancellation fee. I have read and understand Porters Neck Counseling's cancelation policy as outlined in my intake paperwork. Furthermore, three (3) consecutive "no shows" or cancelled appointments will result in discharge from the office.
6. _______I agree and understand that controlled substance medication alone may not be sufficient treatment for my condition, and I agree to participate in at least two (2) individual counseling sessions per month provided by my rendering physician's office as discussed and agreed upon as a part of my treatment plan. In the event I seek additional counseling services provided by another office I will agree to sign a release of information allowing both of my providers offices to exchange information pertaining to my treatment.
7. _______I agree not to sell, share, or give any of my medications to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in immediate termination of treatment without any recourse for appeal.
8. _______I agree not to conduct any illegal or disruptive activities in the office. I understand that if any illegal or disruptive activities are observed or suspected by employees of this office and/or my pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal. I agree not to obtain any medications from any doctors, pharmacies, or other sources without notifying my treating physician.
9. _______I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse effects.
10. _______I understand that mixing medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also understand that mixing medications with alcohol and any other illegal substances can be dangerous and/or life threatening. I recognize that several deaths have occurred among persons mixing controlled substances (especially if taken outside the care of a physician, using routes of administration other than as prescribed or in higher than recommended therapeutic doses).
11. _______I agree to take my medication as instructed and not to alter the way I take my medication without first consulting my doctor. I understand that it is my responsibility to keep my medications in a safe, secure place and agree to do so. I understand and agree that my medications will not be replaced regardless of why they were lost.
12. _______I agree to only receive controlled substance treatment from Porters Neck Counseling.

Porters Neck Counseling, LLC
8044 Market Street Unit D Wilmington, NC 28411 Phone: 910.686.3505 Fax: 910.821.5116

13. _______I agree to random urine drug screens provided by my rendering physician's office and as required by law and I understand that positive drug screens for any illicit drugs will result in discharge from this office. I understand that I will be required to participate in random drug screens as requested by this office and I will have a 48-hour window to go to the office to provide my urine specimen after being contacted by phone or email by a staff member of Porters Neck Counseling. Example: if someone from the treating office calls you, you will have 48 business hours to stop by the office to complete a urinalysis. Failure to do so could result in discharge from the office.
14. _______I agree, understand, and consent, and grant permission to Porters Neck Counseling to send my drug screens to the medical laboratory of their choice for confirmation and verification of lab results. Furthermore, I grant permission to the rendering medical laboratory to bill myself or my health insurance for all services provided.
15. _______I agree not to arrive to the office intoxicated or under the influence of any illegal drugs. If I do, I understand that I will not be provided with any medication or future services at Porters Neck Counseling.
16. _______I understand that operating a motor vehicle while taking some medications and/or controlled substance medications may impair my functioning and/or judgment and I agree that it is my responsibility to comply with the pharmacy disclaimers on my prescriptions as well as with state laws and guidelines pertaining to operating a motor vehicle while taking the prescribed medication and/or under the influence of my medications. If I violate this term and should it result in any sort legal percussion or action I agree that I have been warned and that I will hold this office completed harmless.
17. _______I agree to abstain from the use of alcohol, opioids, marijuana, or any other addictive substance (except nicotine).
18. _______I understand and agree to a fifty ($50) paperwork fee for any documentation outside of a regular office visit with my physician. Furthermore, I understand and agree that Porters Neck Counseling does not provide workers compensation, court ordered or disability paperwork of any kind.
19. _______I agree to provide my current and correct insurance information to Porters Neck Counseling in a timely manner and furthermore understand that if I fail to provide updated insurance information or do not have insurance coverage my visits are subject to self-pay rates to be paid at the time of service.
20. _______I agree that the medication I receive is my responsibility and that I will keep it in a safe and secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss. Furthermore, our offices are associated with the Narcotic Database and all prescriptions can be tracked from 2007 to present.
21. _______I understand that a violation of any one of the aforementioned terms is grounds for immediate termination of my treatment with Porters Neck Counseling and I may be discharge from the office.
22. _______I understand that my treatment may be discontinued, and I may be discharged from this office if I am found in violation of any part of this treatment agreement. Furthermore, I agree to accept the terms outlined in this agreement and understand that should any incident occur due to my neglect and violation of this contract that I will hold Porters Neck Counseling, LLC, and any affiliates with this office harmless from any and all claims or assertions of every kind and nature including all damages, costs, expenses, and fees (including attorneys' fees) resulting from such breach.

______________________________ ________________
Patient's Signature Date

______________________________ ________________
Witness Signature Date

Porters Neck Counseling
8044 Market Street Unit D Wilmington, NC Phone: 910.686.3505 Fax: 910.821.5116

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

This form when completed and signed by you, authorizes the mutual exchange of protected information from the clinical record of (patient name) ______________________ to the person you designate.

Patient's Name: ____________________________ Date of Birth: ____________________________

Previous Name: ____________________________ Social Security#: ___________________________

I authorize my provider, ______________________________ (8044 Market Street Unit D, Wilmington, NC 28411, 910-686-3505) and/or his or her administrative and clinical staff to exchange the following:

_____ Full Clinical Health Information Record
_____ Test Data Only (Name Tests) ____________________
_____ Information Specifically Named: __________________

This information should only be exchanged with (name and address of person to whom the information is to be exchanged):

Name: ____________________________________
Address: __________________________________
____
Phone: _________________ Fax: ______________

I am requesting this exchange for the following reasons: ("at the request of the individual" is all that is required if you are the patient and you do not desire to state a specific purpose.)

____

This authorization shall remain in effect for _______________ or until _____________________
(mo., year, etc.): (mo., year, etc.):

I have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address. However, my revocation will not be effective to the extent that my provider has already taken action in reliance on the authorization or if this authorization was obtained as a condition of obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my provider generally may not condition mental health services upon my signing an authorization unless the mental health services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

___________________________ ___________________________
Signature Date

___________________________ ___________________________
(Print name of signer) (Relationship to Patient)

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

(Photocopies of this form are acceptable)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU CAN BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES
EFFECTIVE APRIL 13, 2003

The following is the privacy policy ("Privacy Policy") of Porters Neck Counseling, ("Covered Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

<u>Without Your Consent</u>

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose you personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include (a) billing and collection activities and related data processing; (b) actions by health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provisions of benefits under is health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premium reimbursement.

Examples of health care operations include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualification of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

<u>As Required By Law</u>

We may use or disclose your personal health information to the extent that such or disclose is requires by law and the use or disclose complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required to disclose your personal health information include (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to public food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social services or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes, or tissue; (g) for research purposes under certain conditions; (h) military and veteran activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may be of interest to you. We will make every effort to obtain your consent prior to leaving voice messages on voice mail or answering machines.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. You may request restrictions on the following uses or disclosures; to carry out treatment, payment, or healthcare operations; (a) disclosures to family members, relatives, or close personal friends or personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (b) instances in which you are not present or your permission connate practicably be obtained due to your incapacity or an emergency circumstance; (c) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right receive confidential communications of your personal health information. We may require written requests. We may condition the rovision of confidential communications on you providing us with information as to how payment will be handled and specifications of an alternative address or ther method of contact. We require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could ndanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential asis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by lternative means or alternative locations.

Right To Inspect And Copy Your Personal Health Information

Your designated record is a record we maintain that includes medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy of your personal health information contained in your designated record, except for (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form of format requested by you, if it is readily producible in such form or format, or, if not, in a reasonable hard copy form or such form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide explanation of the personal health information to which access with access as requested in a timely manner, including arranging with you a convient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonable attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to dent access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct you request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record, for as long as the designated record is maintained by us. We have the right to deny your request for amendment if; (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the request amendment. The Medical Record Amendment Policy and Medical Record Amendment Request Form are available for you upon your written request. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you

do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statement of disagreement will be included in your designated record. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within reasonable time to persons identified by you as having received personal health information of your prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeable rely, on such information to your detriment. All requests for amendment shall be sent to your treatment provider, at 8044 Market Street, Unit D, Wilmington, NC 28411 (910) 686-3505.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date requested. Such disclosures will include the date of each disclosure, the name and, if know, the address of the entity or person who received the information, a brief description of the information disclosed, a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to your treatment provider at 8044 Market Street, Unit D, Wilmington, NC, 28411 (910) 686-3505.

Complaints

You may file a complaint with your treatment provider and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint by mail or hand delivery to your treatment provider, at 8044 Market Street, Unit D, Wilmington, NC, 28411 (910) 686-3505. The Privacy Complaint Policy and Privacy Complaint Form are available for you upon request. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirement of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintained even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or by electronically within 60 days of the effective date of such revision, amendment, or change.

On-Going Access to Privacy Policy

You will be provided with a copy of the most recent version of this Privacy Policy, further information regarding the privacy of our personal health information, and/or information regarding the filing of a complaint at any time upon your written request sent to your treatment provider at, 8044 Market Street, Unit D, Wilmington, NC, 28411 (910) 686-3505.