RESTORATION PLACE COUNSELING
336.542.2060

1301 CAROLINA STREET, SUITE 114
GREENSBORO, NC 27401

CONFIDENTIAL CLIENT INFORMATION

Client Name _____ DOB _____ Age_____

Address _____

City _____ State _____ Zip _____

Phone: Work _____ Home _____ Cell _____

Email _____

Employer _____ Occupation _____

Marital Status: Single____ Married____ Divorced____ Separated____ Widowed____

Race: African American____ Asian____ Caucasian____ Latino/Hispanic____ Native American____ Other____

Religion: Christianity____ Buddhism____ Hinduism____ Islam____ Judaism____ Other____ None____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Did you hear of RPC from a Church, Physician, or other Counseling Professional? Yes_____ No_____

If yes, please specify _____

If no, how did you hear about RPC? _____

Have you ever been seen by a Counselor at Restoration Place? If yes, please name counselor and approximate date of last treatment _____

What would you like to gain from counseling?

_____

_____

_____

What are the most significant stresses that you are currently dealing with?

_____

_____

_____

There are 10 pages in this document. Please make sure you have printed and completed each page (numbered 1 – 10) and that you have initialed and signed where required.

Severity Measure for Generalized Anxiety Disorder – Adult

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. Please respond to each item by marking (√ or X) one box per row. Clinician will tally final score.

							Clinician Use
	During the past 7 days, I have…	Never	Occasionally	Half of the Time	Most of the Time	All of the Time	Item Score
1	felt moments of sudden terror, fear, or fright	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
2	felt anxious, worried, or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
3	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
4	felt a racing heart, sweaty, trouble breathing, faint, or shaky	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
5	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
6	avoided, or did not approach or enter, situations about which I worry	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
7	left situations early or participated only minimally due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
8	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
9	sought reassurance from others due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
10	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
						Total Score	
						Level of Severity	

Severity Measure for Depression – Adult

Instructions: Over the last 7 days, how often have you been bothered by any of the following problems? (Use √ to indicate your answer.) Clinician will tally final score.

						Clinician Use
		Not at All	Several Days	More than Half the Days	Nearly Every Day	Item Score
1	Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3	
2	Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	
3	Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3	
4	Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3	
5	Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3	
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3	
7	Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3	
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3	
9	Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3	
					Total Score	
					Level of Severity	

Client Name: _____ DOB: _____ Date of Update:_____ CsIr: _____

FEES FOR SERVICES AGREEMENT

Standard 55-minute sessions at RPC are billed at $120.00 per session. We offer a significantly-discounted sliding fee scale for those clients who choose not to utilize insurance coverage to pay for services or who do not participate in one of our in-network insurance providers.

Please read and initial each term of this fees and services agreement as explained below.

___ **Payment Responsibility** The client is responsible for payment of his/her own bill. In the case of a minor, the parent or guardian who signs this form is responsible for payment. Payment includes co-pay, deductible, or co-insurance for clients with eligible coverage through insurance and/or fees based on our sliding scale. Fees for clients without eligible coverage through insurance will automatically be calculated based on our sliding scale. The client will be responsible for full payment of insurance claims that are denied. RPC reserves the right to collect full payment in advance from an insurance client when client is in a grace period due to non-payment of premiums. Any overage remaining after payment from insurance will be credited to the client's account or reimbursed to client if requested.

___ **Annual Household Income (AHI) Documentation** Clients using the RPC Sliding Scale are required to annually complete the Sliding Scale Eligibility Worksheet and provide proof of total gross **A**nnual **H**ousehold **I**ncome **(AHI)** in order to determine their placement on our sliding scale of fees. Clients who do not provide current AHI will be subject to our standard fee. AHI includes all adults living within the home who contribute to household expenses. Acceptable forms of AHI include most recent tax return, W-2, 2 or more paystubs, letter from employer, self-employment ledger, social security or unemployment benefits letter, or termination paperwork.

___ **Fees for Phone Consultation, Documentation, Court Appearances** Any phone contact between client and counselor other than scheduling appointments, including but not limited to phone sessions, writing letters, appearing in court, etc., is considered consultation and will be charged at an hourly rate of **$50.00**, pro-rated by the quarter hour.

___ **Payment Terms** All payments, including co-pays and/or deductibles, are due at the beginning of each session. ***If payment is not made at that time, your session will be rescheduled.*** Fees are payable by cash, check or major credit card. There is a convenience fee of $2.00 for all credit card payments. For clients with insurance coverage, if your insurance fails to pay, you will be responsible for the full payment of the allowable amount contracted and set by the insurance company. Any client with two (2) outstanding invoices will not be scheduled for a session until balance is paid in full. Prepaid balances of funds less than $25 will not be refunded after 90 days following the treatment termination.

___ **Fees for No-Shows or Late-Cancelled Appointments** It is our policy to require 24 business hours notification for any cancellation or rescheduling of appointments. All clients not adhering to this policy will be charged a fee of **$40** for each no show or late-cancelled appointment, regardless of their sliding scale fee or insurance coverage. Insurance does not pay for missed or late cancelled appointments; therefore, the client will be responsible for the full amount of this fee. All clients are required to have a current credit card on file. Card will be automatically charged for no shows and late cancels unless otherwise paid within the allotted time frame. (See attached authorization form.) Email and text reminders are a courtesy only. It is the client's responsibility to attend all scheduled appointments. Lack of receipt of either of these reminders does not excuse a late cancellation or no show as RPC cannot guarantee delivery of such reminders.

___ **Late Arrivals** Any client who arrives more than 15 minutes past their scheduled appointment time will be considered a late cancellation/no-show unless prior arrangements have been made with counselor. An intake client (1st time client), will be considered late if client has not completed all necessary paperwork by at least 15 minutes after the scheduled appointment time. Late clients will be required to reschedule and will be charged according to late policy. (See section above for late policy.)

___ **Returned Checks** All checks returned as NSF (insufficient funds) require a cash payment of the check amount plus a $25 service fee prior to scheduling additional sessions with counselor.

___ **Release of Information/Assignment of Benefits** Clients who choose to utilize insurance as payment or to file other insurance for reimbursement give authorization to Restoration Place Counseling to release information to their insurance company relating to all claims for benefits. For clients requesting reimbursement by their out-of-network insurance company, the billing administrator will sign off on insurance forms for you to submit to your insurance company directly; however, full payment of your determined fee is due at the time of the session.

___ **Change of Fees** Client is responsible for notifying RPC in a timely manner of <u>any</u> changes in household income or insurance benefits.

Read the following and select one:

_____ **PAYMENT OPTION 1:** I choose for RPC to file with my in-network insurance provider for counseling services. (Insurance clients must present a current, valid insurance card at the first appointment in order to use insurance.)

☐ I have coverage through Blue Cross Blue Shield.
☐ I have coverage through Cigna.
☐ I have coverage through CBHA – Carolina Behavioral Health Alliance.

_____ **PAYMENT OPTION 2:** I choose to use the RPC Sliding Scale.

☐ I do not have insurance coverage and will be using the RPC sliding scale.
☐ I have other insurance coverage not accepted at RPC. I will be using the RPC sliding scale.
My insurance carrier is: _____
☐ I decline to use my insurance for services at RPC. I will be using the RPC sliding scale.

If you chose Payment Option 1 above, please complete the rest of this page. If you chose Payment Option 2 above, please sign the bottom and skip to the following page.

Client Name as Listed on the Insurance Policy: _____

Client's Individual Subscriber ID # (please include all letters/numbers): _____

Group # (if applicable): _____

Client's Date of Birth (mm/dd/yyyy): _____/_____/_____

Client's Relationship to Policy Subscriber: Self Spouse Child

If you are the Spouse or Child of the Policy Subscriber, please complete the following:

Subscriber's Name as Listed on the Insurance Policy: _____

Subscriber's Date of Birth (mm/dd/yyyy): _____/_____/_____

Subscribers Complete Address: _____

Subscriber's Gender: Male Female

_____ _____

Signature (for pages 3-4) Date

If you chose Payment Option 2 above, please complete the rest of this page. If you chose Payment Option 1 above, please skip to page 7.

SLIDING SCALE ELIGIBILITY WORKSHEET

As explained in the Fees for Services Agreement (page 3), the Sliding Fee Scale is calculated according to the Gross (pre-taxed) Annual Household Income for one year. All clients who wish to take advantage of our sliding scale of discounted fees must complete this form annually and provide the necessary documentation. All parties / adults who contribute to the household income should be included. If you can be claimed as a dependent on someone else's income tax return, your fees will be based on their income amount. Acceptable forms of documentation include most recent tax return, W-2, 2 or more paystubs, letter from employer, self-employment ledger, social security or unemployment benefits letter, or termination paperwork. Clients who do not provide proof of income will be charged the standard rate of $120/session until that proof is received.

Client Name _____ Today's Date ____/____/_____

How many people, including the client, live in the household? _____ Please list all members of the household, with age, relationship to client, and estimated salary/wages, below.

Name	Age	Relationship to Client	Estimated Salary/Wages	Pay Frequency	Employer
1) Client		Client			

Weekly = paid every week. **Bi-Weekly** = paid every other week. **Bi-Monthly** = paid 2 times per month. **Monthly** = paid 1 time per month.

Other Monthly Income for ALL Household Members (including minors)	
Social Security	$
Disability	$
Alimony/Separation Payments	$
Child Support	$
Retirement Pension	$
Interest Income	$
Rental Income	$
Unemployment Benefits	$
Family Member Support	$
Other	$

SLIDING SCALE ELIGIBILITY WORKSHEET CONT'D

I affirm that the information provided on this eligibility worksheet is true and correct to the best of my knowledge. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding scale fee option. I further agree to inform RPC if there is a significant change in my income and/or financial circumstance. I acknowledge that I have read and fully understand the Sliding Scale Eligibility Worksheet. (If you have requested an additional discount above, RPC will review your request and provided documentation. You will be notified of a decision within 7-10 business days. A discounted fee can be any amount on our scale but will be no less than $25 per session.)

_____ _____

Signature (for pages 5-6) Date

RPC Sliding Scale	
If your gross household income is:	**Then your fee per 55-minute session is:**
Under $30,000	$25.00
$30,000 – 34,999	$30.00
$35,000 – 39,999	$35.00
$40,000 – 44,999	$40.00
$45,000 – 49,999	$45.00
$50,000 – 54,999	$50.00
$55,000 – 59,999	$55.00
$60,000 – 69,999	$60.00
$70,000 - 79,999	$70.00
$80,000 – 89,999	$80.00
$90,000 – 99,999	$90.00
$100,000 -150,000	$100.00
$150,000 + (Standard Rate)	$120.00

*All clients who are uninsured or who elect not to use their insurance coverage will be considered eligible for the RPC sliding scale as long as acceptable proof of household income has been received. Clients who wish to seek a further discount based on financial hardship may do so only after they have completed 5 or more sessions. Proof of financial hardship will be required in addition to the original income documentation. This includes regular monthly bills, medical bills, debts, all monies going out of household on a monthly basis. Please contact our Billing Manager at heather@rpcounseling.org if you feel you should be considered for an additional discount.

For RPC Office Use Only	
Salary/Wages Total	$
Other Income Total	$
AHI Total	$
Sliding Scale Fee	$
Approved By	

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY. YOUR PRIVACY IS IMPORTANT TO US.

Your record contains personal information about you and your health. This information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use or disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control you PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at the time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

FOR TREATMENT: Your PHI may be used or disclosed by those involved in your care for providing, coordinating, or managing your health care treatment and services. We may disclose PHI to other consultants only with your authorization.

FOR PAYMENT: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples are making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

FOR HEALTHCARE OPERATIONS: We may use and disclose, as needed, your PHI in order to support our business activities. For example, we may share your PHI with third parties that perform various business activities (e.g. billing or data entry services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes, PHI will be disclosed only with your authorization. We may use your PHI to call or write to you of appointments and to inform you of additional services or treatment alternatives that are available to you.

REQUIRED BY LAW: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigation or determining our compliance with the requirements of the Privacy Rule.

LIMITED RIGHT TO USE NON-IDENTIFYING PERSONAL INFORMATION FROM BIOGRAPHIES, LETTERS, NOTES AND OTHER SOURCES: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Restoration Place Counseling. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fund-raising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information

and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without the client's express advanced permission.

You may specifically request that NO information be used whatsoever for promotion purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

THE FOLLOWING IS A LIST OF THE CATEGORIES OF USES AND DISCLOSURES PERMITTED BY HIPAA WITHOUT AUTHORIZATION:

Abuse and Neglect	**Judicial/Administrative Proceedings**	**Emergencies**
Law Enforcement	**National Security**	**Public Safety (Duty to Warn)**

Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as state licensing boards or health department).
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

YOUR RIGHTS REGARDING YOUR PHI: You have the following rights regarding your personal PHI maintained by our office.

- **Right of Access to Inspect and Copy** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We reserve the right to charge a reasonable fee for copies.
- **Right to Amend** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree with the request.
- **Right to Request Confidential Communication** You have the right to request that we communicate with you about medical matters in a certain way or in a certain location.
- **Right to a Copy of this Notice**
- **Electronic Transaction Standards**

QUESTIONS AND COMPLAINTS: If you have questions about this notice or think your privacy rights have been violated by us, or you want to complain to us about our privacy practices, please contact Ms. Cindy Mondello, Executive Director of Restoration Place Counseling, at 336-542-2060. You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. If you file a complaint, we will not take any retaliatory action against you or change our treatment of you in any way.

_____ _____

Signature (for pages 7-8) Date

CONSENT FOR SERVICES at RESTORATION PLACE COUNSELING

This document contains important information about our professional services and business policies. The law requires that we obtain your signature acknowledging that we have provided you with this information before we begin sessions. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement at any time in writing.

SESSIONS, FEES, AND CONTACTING OUR OFFICE

Sessions are 55 minutes unless prearranged differently. Because other clients may be scheduled before and after you, RPC asks that you arrive on time. As well, the RPC staff is committed to respecting your time and following the appointment schedule. If an emergency occurs that prevents a therapist from beginning your session on time, your therapist will step out and inform you of this. If you are unable to keep an appointment, please call to cancel or reschedule at least 24 hours in advance to avoid late cancellation or no-show fees.

Payment is expected at the beginning of each session, payable by check, cash, or credit/debit card. Please see the attached Fees for Services Agreement for details regarding payment, amount of session fee, etc. RPC files BCBS, CIGNA, and CBHA health insurance only, and is willing to give you a receipt for any other coverage provider for which to file yourself. Health insurance companies often require that agencies provide a diagnosis and indicate the reason for treatment before they agree to reimburse you. In the event a diagnosis is required, your therapist will inform you of the diagnosis prior to submission to the health insurance company. Any diagnosis made will become part of your permanent insurance record.

Our office may be contacted Monday through Friday from 9am – 4:30pm. We make every effort to answer all phone calls; however, if we are unavailable or helping another client, your call will be transferred to a confidential voicemail. Calls will be returned within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform us of times when you will be available for a return call.

CONFIDENTIALITY AND SUPERVISION

In order to provide you with a trusting therapeutic environment, RPC will maintain confidentially of our communication. This means that what you share is private and protected by law, and only under certain legal obligations or at your written consent is RPC able to disclose this privileged information. All communication, including diagnosis and treatment planning, becomes part of your permanent clinical record that is kept in a secure location at RPC. You have the right to request a copy of your record, and this request must be made in writing. In the case of unforeseen circumstances such as death or incapacitation, your files will remain held securely and confidentially by RPC.

The following are exceptions to confidentiality: (1) if you disclose that you intend to harm yourself or someone else; (2) if your counselor determines that you are a danger to yourself or someone else; (3) if information is revealed about alleged child, elder, or disabled adult abuse, even if suspected by a third party; (4) if your records are ordered from me by a court of law or if you subpoena your records; and, (5) if you take legal action against RPC, you forfeit your right to confidentiality. If you wish to contest the disclosure of your records under these (4, 5) circumstances, you may do so in writing within ten (10) days of our office receiving notice of the records request.

If you choose to communicate via e-mail or text message, please know that RPC cannot ensure nor will it be held responsible for a breech in confidentiality. E-mail and text messaging have no confidentiality in the view of the court, and RPC advises against its use. Each RPC counselor reserves the right to decide whether she will communicate in this way.

Please check the appropriate box below related to email and text message communications:

☐ I agree to receive communication via email for appointment reminders and related information
☐ I do NOT agree to receive communication via email

☐ I agree to receive text messages for appointment reminders and related information
☐ I do NOT agree to receive text messages for appointment reminders and related information

MINORS AND PARENTS

Clients under 18 years of age who are not emancipated (and their parents) should be aware that the law allows parents to examine their child's treatment records unless we believe that doing so would endanger the child. Because privacy in services is often crucial to successful progress, particularly with teenagers, it is our policy to request from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and the child's attendance at scheduled sessions. Any other communication will require the child's Authorization to Release Information, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of the concern. Before giving parents any information, we will discuss the matter with the minor, if possible, and will do our best to handle any objections the child may have.

CONSENT FOR EMERGENCY CARE

In the event of an emergency, you authorize RPC to seek emergency medical/dental care if you become ill or have an accident while participating in services. This shall include emergency first aid rendered by staff. You agree to hold harmless RPC and its personnel from liability caused by their taking any emergency procedures and or/contacts. You will assume the full responsibility of all incurred emergency treatment expenses.

ACCEPTANCE AND CLOSURE

Should your RPC counselor feel that she cannot continue to help you utilizing the techniques she has available, she will discuss this with you and refer you to another professional either within RPC or externally based on your preference. Should you decide to end counseling at any point, RPC will respect your decision and assist in transitioning you to another preferred provider.

AGREEMENT

Thank you for the privilege to serve you. Unless revoked in writing by you, this consent is valid until one year from the date this consent is signed, and will be updated annually.

Your signature below indicates that you understand and agree to all of the items outlined above and consent to services.

_____
Print Name of Client

_____ _____
Signature of Client (for pages 9-10) Date

_____ _____
Signature of Parent or Legal Guardian (if applicable) Date