ASCEND PSYCHOLOGICAL SERVICES, PLLC

Rockwell, NC 28138

Demographic Form

Date_____

Client Name: _____Date of Birth: _____

Preferred Name: _____ **Gender** - *Male* *Female* **Marital Status** Married Single Other

Parent/Guardian_____ Relationship _____

Parent/Guardian legal custody papers ___YES __ NO Office will need to make copy of for children under age 18- **BRING TO OFFICE**

Mailing Address _____ Phone – Home #_____

City, State Zip Code_____ Mobile #_____

Email Address:_____

Do you want to receive email and/or text for appointment reminders? *YES* *NO* *EMAIL* *TEXT*

Employer _____ Work # _____

Insurance Provider: _____ Insurance Policy #_____

Policy Holder Name: _____DOB:_____Insurance phone #_____

Name and Contact Information of referring physician (if any): _____

Reason for today's visit: _____

_____

Psychiatric History: _____

_____

Medical History: _____

_____

Medications: _____

_____

Allergies: _____

_____

ASCEND PSYCHOLOGICAL SERVICES, PLLC
110 A East Main Street
P. O. Box 271
Rockwell, NC 28138
Ph: Office - 704-279-0626
Fax: 704-279-0344

Client Rights

- The Confidential handling of records
- Participation in the development of client's treatment plan
- Having an Individualized, written treatment plan within 30 days of admission to Ascend Psychological Services, PLLC
- Having all civil rights, including the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, register and vote, bring civil actions, and marry and get a divorce, unless the exercise of a civil right has been precluded by an unrevoked adjudication of incompetency
- To dignity, humane care, and freedom from mental and physical abuse, neglect, and exploitation
- To treatment, including access to medical care and habilitation, regardless of age or degree of mh/dd/sa disability. To receive necessary treatment for prevention of physical ailments.
- To live as normally as possible while receiving care and treatment and receive age-appropriate treatment for diagnosis. To have opportunities that enable the individual to mature physically, emotional, intellectually, socially, and vocationally to include special education and training in accordance with state and federal law
- To be free for unnecessary medications and for medication not to be used for punishment, discipline, or staff convenience
- Notification that release / disclosure of information may only occur with an authorization or consent unless it is an emergency or for other exceptions as detailed in G.S. or 164.512 of HIPPA
- Right to only release minimum information necessary for coordination of care and services
- Access to a clinician in the case of emergency
- Effective communication while receiving care, treatment, and services, including any complaints about patient care
- The right to consent to or to refuse treatment
- The right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD) to protect and advocate for my rights:

  Phone: 919-856-2195 or 877-235-4210
  Email: info@disabilityrightsnc.org
  Mail: Disability Rights, 3724 Nation Drive, Suite 100, Raleigh, NC 27612
  Fax: 919-856-2244

My signature below verifies that I have read and understand my Client Rights.

_____ _____

Signature Date

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Authorization to Disclose Health Information

Client Name: _____ Date of Birth: _____
Client Medical Record #: _____ Client Insurance: _____

I hereby authorize Ascend Psychological Services, PLLC to exchange specific health information from the records of the above named client with

_____

_____

_____

for the specific purpose(s) _____

Specific information to be exchanged: _____

I understand that this authorization will expire on the following date, event, or condition: Client's termination of services with Ascend psychological Services, PLLC.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
Signature of Client	Date	Witness (if required)
_____	_____	_____
Signature of Personal Representative	Date	Personal Representative Relationship/Authority

***Note: this authorization was revoked on: _____ _____
Date Signature of Staff

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Outpatient Services Contract

Welcome to Ascend Psychological Services, PLLC. This document contains important information about Ascend's professional services and business policies. Please read it carefully and ask any questions you might have. When you sign this document, it will represent an agreement between us.

PSYCHOTHERAPY

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular presenting problem(s). Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first session or two will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. If you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional.

MEETINGS

I normally conduct an evaluation during your first session. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week, although some sessions may be longer, shorter, or more or less frequent. If you are unable to attend an appointment, you are expected to provide 24 hours advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment. If you do not attend your sessions on a regular basis, I reserve the right to discontinue working with you.

PROFESSIONAL FEES

My hourly fee is the amount paid by your insurance company. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. (Because of the difficulty of legal involvement, I charge $100 per hour for preparation and attendance at any legal proceeding.)

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. (In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.)

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon. I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. (If such legal action is necessary, its costs will be included in the claim.) In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out

forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from you insurance company. If necessary, I will be willing to contact the company on your behalf.

Due to rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short term therapy, some patents feel that they need more services after insurance benefits end. (Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.)

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if your benefits run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charge an appropriate fee for any professional time spent in responding to information requests.

MINORS

If you are under eighteen years of age, please be aware that the law provides your parent(s) the right to examine your treatment records. It is my policy to provide your parent(s) only with general information about our work together, unless I fell there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist/counselor is protected by law, and I can only release information about our work to others with the client's written permission, or with permission of the client's legally responsible person. This release is valid for a specified length of time and is subject to revocation by the consenting individual.

I may need to disclose the fact of admission or discharge of a client to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.

Upon request a client shall have access to confidential information in his client record except information that would be injurious to client's physical or mental well-being as determined by the attending clinician. If the attending clinician has refused to provide confidential information to a client, the client may request that the information be sent to a physician or psychologist of the client's choice, and in this event the information shall be so provided.

Except as provided by G. S. 90-21.4(b), upon request the legally responsible person of a client shall have access to confidential information in the client's record; except information that would be injurious to the client's physical or mental well-being as

determined by the attending clinician. If the attending clinician has refused to provide confidential information to the legally responsible person, the legally responsible person may request that the information be sent to a physician or psychologist of the legally responsible person' choice, and in this event the information shall be so provided.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings, however, a judge may order my testimony if he or she determines that circumstances demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality can be complex, and I am not an attorney.

CONTACTING
Office phone number is 704-279-0626. Office fax number is 704-279-0344.
Emergency contact – Dr. David Maxwell - 704-202-2056. Email is david@ascendpsy.com
However, I am often not immediately available. For example, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by confidential voicemail. I will make every effort to return you call within 24 hours of when you make it, with exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call contact you family physician or the nearest emergency room and ask for the psychologist (psychiatrist) on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Your signature below also indicates that you have been informed of you client rights.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent (Guardian) Date

_____ _____

Signature of Clinician Date