Greene Psychology Group

901 Paverstone Drive, Raleigh, NC 27615 – 919-205-5339 –

www.greenepsychologygroup.com

NEW CLIENT WELCOME PACKET

Welcome to our practice!

Please review attached documents prior to your initial meeting. Your therapist will be available to answer any questions you may have. The packet includes the following:

1. New Client Registration Form
2. North Carolina – Notice of Policies to Protect the Privacy of Your Health Information/HIPAA
3. Client Agreement for Services – please note that this requires you to sign in two different places to consent to treatment and to indicate that you have received all documents.
4. Telehealth Consent
5. Credit Card Authorization –Please complete if you would like to keep a credit card on file.

If you need a release of information form, they are available on our website or directly from your therapist.

Thank you!

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NEW CLIENT REGISTRATION

CLIENT INFORMATION:

Client Name:_____ Pronouns: _____

Client Date of Birth: _____ Legal Gender: _____

Address: _____

City, State, Zip: _____

Phone: _____Email: _____

PAYMENT/BCBS Insurance

Plan Type: _____ Employer Name: _____

Subscriber ID: _____

Subscriber Name: _____ _____

Subscriber DOB:_____

Relationship to Client:_____

OR

PAYMENT/Self-Pay:

Name of Person Responsible for Payment: _____

Date of Birth of Person Responsible for Payment: _____

PRESENTING CONCERNS:

What are your primary concerns? _____

_____

What do you hope to obtain from services?_____

_____

REFERRAL: How did you hear about us?

Online (please circle): Google Good Therapy Psychology Today BCBS directory

Personal or Professional Referral: _____

Other:_____

FOR CHILDREN UNDER 18 ONLY:

Parent/Legal Guardian & relation (if client under 18): _____

School/Grade: _____

Please indicate any custody arrangements, if applicable:_____

For Office Use Only:

Date Completed:_____

Assigned Therapist: _____

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NORTH CAROLINA NOTICE FORM

Notice of Psychologists' Policies to Protect the Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice conforms to the Federal Health Insurance Portability and Accountability Act (HIPAA) and will go into effect on April 14, 2003. It also conforms to the health care privacy laws of North Carolina. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Laura Greene, Psy.D., PLLC (DBA: Greene Psychology Group) may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  - Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Greene Psychology Group may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain

an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Greene Psychology Group may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If you give us information that leads us to suspect child abuse, neglect, or death due to maltreatment, we must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, we must do so.
- Adult and Domestic Abuse: If information you provide gives us reasonable cause to believe that a disabled adult is in need of protective services, we must report this to the Director of Social Services.
- Serious Threat to Health or Safety: We may disclose your confidential information to protect you or others from a serious threat of harm by you.
- Health Oversight: Our professional licensing boards have the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.
- Worker's Compensation: If you file a workers' compensation claim, we are required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding, and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance.

IV. Client's Rights and Psychologist's Duties

CLIENT'S RIGHTS

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are

not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send bills and other correspondence to another address.)
- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of the Notice). On your request, we will discuss with you the details of the accounting process.
- Right to a Paper Copy: You have the right to obtain a paper copy of the notice from us upon request.

PSYCHOLOGIST'S DUTIES

- Greene Psychology Group is required by law to maintain the privacy of PHI and to provide you with a notice of her legal duties and privacy practices with respect to PHI.
- Greene Psychology Group reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a revised notice on our website (www.greenepsychologygroup.com) and a copy will be available upon request.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, please bring this to our attention immediately. You may also send a written complaint to the Secretary of the US Department of Health and Human Services.

*Greene Psychology Group reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting a revised notice on our website (www.greenepsychologygroup.com) and a copy will be available upon request.

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CLIENT AGREEMENT FOR SERVICES

Welcome and thank you for choosing Laura Greene, Psy.D., PLLC (DBA: Greene Psychology Group) for the opportunity to provide you with therapy services. Greene Psychology Group is a dedicated group of independent mental health providers. Each provider holds a Master's or Doctoral degree in Psychology, Counseling or Social Work and is licensed to practice in the state of North Carolina. Each provider is solely responsible for the rendering of clinical and non-clinical services when working together with you. We look forward to working with you. Please review this agreement carefully and let us know if you have any questions or need any clarification.

OFFICE POLICIES:

APPOINTMENTS/COMMUNICATIONS: Your therapist can be reached at the number listed above to schedule an appointment or for other inquiries. At times, our therapists may be in session with clients and unable to answer the telephone. If this should occur, please leave a message on our confidential voicemail. Your call will be returned promptly. Please note that email while email can be a convenient form of communication for non-clinical issues (e.g. scheduling appointments), it is not a secure form of communication and does not ensure confidentiality. By providing your email address above, you are agreeing to permit our therapists to contact you via email regarding non-clinical issues.

MISSED APPOINTMENTS/LATE CANCELLATIONS: When you schedule an appointment, the time is reserved specifically for you. If you are unable to keep the appointment or need to reschedule, please do so as soon as possible. Appointments cancelled without **at least 48-hour** notice will be charged a Missed Appointment/Late Cancellation Fee of $50. Insurance companies do not provide reimbursement for these fees. If missed appointments/late cancellations become excessive (e.g. 5 or more) within a 12-month period, you may be discharged from therapy at the discretion of your therapist.

EMERGENCY SERVICES: **We do not provide emergency services**. If you are experiencing a life-threatening emergency, please call 911, go to your local emergency room or follow emergency procedures per your insurance carrier.

CUSTODY: If a child is presenting for services, it is imperative that we receive consent for treatment/medical care from both parents/all required parties, per custody agreement. A copy of the agreement will be requested for our files. By signing below, you are stating that you have the legal right to consent for your child.

LITIGATION LIMITATIONS: We believe that it is best practice for therapists not to be involved with legal proceedings (e.g. divorce or custody dispute) as to avoid potential negative impacts on the therapeutic relationship. By signing below, you are agreeing that we will not provide court testimony or disclosure of therapy records in any legal proceedings. If records or attendance in court is mandated and your therapist is involved in legal proceedings, you will be billed at an hourly rate of $250 - $350 per hour for all related services (e.g. travel, attendance at court, preparation, report writing, etc.)

CONFIDENTIALITY: All information (e.g. clinical notes, records, test protocols, etc.) will be kept confidential unless written permission is granted otherwise. State law requires that therapists report any concerns regarding a client's intent to harm self or others and suspected child abuse. In some situations, a judge may order records. On occasion, your case may be reviewed with another therapist in order to enhance the services that you receive but identifying information will not be shared.

Please refer to the HIPAA Notice of Privacy Policies for more information that is available in this packet and by request. Our practice follows the guidelines set by the Health Information Portability and Accountability Act. In compliance with HIPAA, client authorizes Greene Psychology Group to release any and all medical information essential to certify the medical necessity and appropriateness of services rendered, and/or to process any claim for reimbursement of charges incurred to the identified insurance company or to any of its contracted/designated agents.

FINANCIAL POLICIES:

PAYMENT: All payment (self-pay or co-pay) is due at the time that services are rendered. Payments by check, cash or credit card are accepted. By signing this form, client assumes full responsibility for all charges for services rendered by Greene Psychology Group.

INSURANCE/FEES: Please be sure to contact your insurance company, prior to obtaining services, to understand your individual benefits and reimbursements.

Greene Psychology Group is in-network with most Blue Cross Blue Shield plans. The client is providing authorization to his/her insurance company to make direct payment to Greene Psychology Group under any and all applicable coverage, for charges resulted from services rendered. **Client will be responsible to pay any charges that are not covered by insurance company.**

Greene Psychology Group is considered as an "out of network" provider with other insurance companies. A statement will be provided to the client that can be submitted directly to insurance carrier for out-of-network benefits, if desired. The client is responsible for submitting his/her own claims to insurance. If client processes a claim with his/her insurance provider, we may be required to release information, including services rendered and clinical diagnosis, if applicable, to the insurance carriers involved in the payment of your account.

Therapy and psychological evaluation fees vary from $100 - $150/hour, depending on services rendered and provider. In addition, the same fees for professional time (e.g. telephone calls, report writing, emails, collaboration with other professionals, etc.) may be incurred, per 15-minute increments.

Overdue balances are subject to a 15% monthly late fee and any returned checks are subject to a $35.00 fee. You are responsible for the fees of any services provided to you. Refunds are not offered once services are rendered. Please discuss any questions regarding the financial policies directly with your therapist for full understanding.

PLEASE PROVIDE CONSENT AND SIGNATURE ON NEXT PAGE.

ACKNOWLEDGEMENT AND CONSENT:

By signing this form, I acknowledge:

I have read the above Client Agreement and had the opportunity to discuss and clarify any questions with my therapist to my satisfaction. I understand the office and financial policies as documented in this Client Agreement.

By providing my signature below, I consent to have Greene Psychology Group provide psychological services and I agree to the terms and conditions of this Client Agreement.

_____

Client Name

_____ _____

Signature of Client Date

OR

_____ _____

Signature of Parent/Guardian & Relation to Client Date

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices for Greene Psychology Group and have had the opportunity to discuss and clarify my questions with my therapist to my satisfaction.

_____ _____

Signature of Client Date

OR

_____ _____

Signature of Parent/Guardian & Relation to Client Date

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SUPPLEMENTAL CONSENT FOR TELEHEALTH SERVICES

TELEHEALTH SERVICES: As a client receiving telehealth services, I understand that telehealth is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client who are not in the same physical location. The interactive technologies used in teletherapy incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

TELEHEALTH AGREEMENTS: The sessions are to occur between the therapist and me, the identified client. I will be informed if any additional personnel or individuals are to accompany me and the provider and I will give verbal permission prior to the session. The therapist will maintain documentation of sessions, similar to those completed for in-office sessions. I will use my personal equipment and not that of others (e.g. employer) which could compromise my privacy. I understand that my healthcare information may be shared with others only in the cases of an emergency, for scheduling and/or billing purposes. My therapist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed. I understand I may decline teletherapy health services at any time without jeopardizing my access to future care, services and benefits. All other client agreements remain consistent with the signed Client Agreement on file.

TECHNOLOGY REQUIREMENTS: I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery. I understand that I will receive a unique URL for each scheduled session. I will need a phone, tablet or computer with a webcam and microphone, a high-speed internet connection and access to a mobile browser (e.g. Google Chrome, Safari, Mozilla, Firefox). I understand that Greene Psychology Group uses a HIPAA compliant teletherapy platform.

TECHNOLOGY RISKS: These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties, equipment

failures or inadequate video quality. If the service is disrupted, the therapist will call me immediately to discuss a plan. I understand that the therapist may ask for a current phone number at the start of each session. I understand that telehealth service delivery is emerging and there may be risks not yet identified.

EMERGENCY PROCEDURES SPECIFIC TO TELEHEALTH SERVICES: There are additional procedures that are in place specific to Telehealth services. I agree to inform you of the address where I am at the beginning of every session. These are for my safety in case of an emergency and are as follows: I understand that if I am having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, the therapist may determine that I need a higher level of care and Telehealth services are not appropriate. My therapist requires consent to contact an Emergency Contact Person (ECP) who she/he may contact on my behalf in a life-threatening emergency only. Additionally, if either my therapist, my ECP, or I determine necessary, the therapist or ECP will contact the local police and/or have me transported to my local hospital. My signature at the end of this document indicates that I understand my therapist will only contact this individual in the extreme circumstances stated above. I consent to sharing information provided here if needed in an emergency. Please list:

Emergency Contact Person (ECP):

Name: _____

Phone:_____

In addition, please list the nearest mental health hospital to your primary location in the event of a mental health emergency and the nearest police department and contact information.

Hospital Name: _____

Phone: _____

Local Police Department: _____

Phone:_____

I understand this form, consent to teletherapy, agree to use these procedures, and have completed the form in its entirely.

Client Name (printed): _____ Date: _____

Signature:_____

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CONSENT FOR CREDIT CARD PAYMENT

Name (as it appears on card): _____

Client Name (if different): _____

Billing Address: _____

Zip Code: _____

Telephone Number: _____ Email: _____

I authorize Laura Greene, Psy.D., PLLC (DBA Greene Psychology Group) to charge my credit card for: (please initial)

____ Session fee in the amount of _____ per transaction.

____ A one-time payment in the amount of _____.

____ Other (Please specify): _____

Type of card: (please circle)

MasterCard Visa Other: _____

Credit Card Number: _____

Expiration Date: ____/____ CVV number: _____

Cardholder Signature: _____ Date: _____

A receipt will be mailed to you.

THANK YOU FOR SELECTING GREENE PSYCHOLOGY GROUP

TERMS OF PAYMENT: PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED. OVERDUE BALANCES ARE SUBJECT TO A 15% MONTHLY LATE FEE. RETURNED CHECKS ARE SUBJECT TO A $35.00 FEE. REFUNDS ARE NOT OFFERED ONCE SERVICES ARE RENDERED.