bewelltherapy, PLLC

PROFESSIONAL OUTPATIENT THERAPY, DWI AND SUBSTANCE ABUSE SUPPORT CENTER

OFFICE POLICIES

Confidentiality

All information you share with us within sessions is held strictly confidential and may not be revealed to anyone without a written release of information, *except* where disclosure is permitted or required by law. We are required to disclose information in the following circumstances:

1. We have a reasonable suspicion that you are a danger to yourself or someone else;
2. When you disclose information about abuse or neglect of a child, elderly, or disabled person;
3. Your therapist is ordered by the court to disclose information;
4. You give us written permission to disclose information.
5. Diagnosis and date of service shared with your insurance company (if insurance is billed for treatment purposes).

If the client is a minor, the legal guardian acknowledges that the child's records are confidential except in the above stated exceptions. In addition to the above, we sometimes consult with professional colleagues to improve the quality of care we provide. Your signature on this form constitutes advance consent for this practice. When discussing "cases", other professionals are also bound to keep this information confidential.

Phone Contact and Emergencies

Majority of our therapists' time is spent in session, therefore phone contact is limited. If at any time you have a question, do not hesitate to contact our office and our office staff will triage the information between you and your therapist. In the event you need to speak with your therapist directly and you have a conversation of information-exchange or solution-focused in nature that lasts more than 10 minutes, you will be charged. Please note insurance companies do not reimburse for communication over the telephone.

In order to best serve the needs of our clients, Be Well Therapy, PLLC has established a crisis response system for emergency situations involving our clients. In the event of an afterhours emergency the client, parent, guardian & or family member can call our crisis response at **(980) 263-4070**. The client, parent guardian &/or family member will be asked to detail the nature of the emergency and respond accordingly. This crisis number is to be used for emergencies that are urgent/critical in nature and cannot wait until the next business day. If the emergency situation is life threatening the client should call **911** for immediate response, call your physician, or go to the local emergency room. You can reach Carolinas Medical Center—Behavioral Health Center Emergency Room at (704) 358-2800 or Presbyterian Behavioral Health Access at (704) 384-4255.

(Please enter a call back number that does not block private numbers)

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FINANCIAL ASPECTS OF CONTRACTING PSYCHOTHERAPY SERVICES:

Insurance Reimbursement

If you have insurance and want your insurance company to cover the cost of your services, we will file insurance claims for you. Please note you are responsible for payment if your insurance plan has an unmet deductible or the claim is denied for service. We encourage you to contact your insurance company to answer questions you may have about the extent to which our fees are reimbursable. We may use and disclose medical information about you so that the services received may be billed and payment may be collected. Please also understand that we may tell your health plan about the treatment you will receive in order to obtain prior approval and determine whether your plan will cover the proposed treatment.

Payment for Services (self-pay/non-insurance)

Service fees are determined by education level, licensure, and years of experience of therapist. The fee in working with a Be Well Therapy, PLLC's therapist is as follows per 60-minute session:

*$65-Individual Therapy and $80-Marital/Family Therapy with associates working toward licensure LPCA

*$95-Individual Therapy, $110-Marital/Family Therapy, and $150.00 Clinical Assessing with fully licensed therapists LPC

*$110-Individual Therapy, $120-Marital/Family Therapy and $200.00 Clinical Assessing with fully licensed therapist supervisor LPCS

*Monthly plans and digital therapy are available

***$15 administrative charge for all initial appointments.**

***$35 fee for any completion of documents requested by Client or a third party**

***Payments Due at Time of Service**: Clients are expected to pay the standard fee for 60-minute session at check-in. Your appointment will be rescheduled if you do not have your copayment. You will not be able to schedule a subsequent appointment if you have an unpaid balance in our office.

Cancellation

We value the time we prepare and spend with each client and therefore the scheduling of an appointment involves the reservation of time specifically for you. We understand things may come up unexpectedly, however, we require a **24 hour cancellation notice to be given to reschedule or cancel an appointment**. In the event of a "No Show" or failure to give a full 24 hour notice to reschedule or of a cancellation, **you will be charged a $35.00.** Please be aware that insurance companies will not cover cancellation charges.

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Services for Legal Issues and/or Court Process

In exchange for a fee of $150.00 per hour, your therapist may provide requested documentation within the scope of practice and court appearance to clients in need of assistance with their legal concerns. Notify and discuss with your therapist before sending a subpoena or authorizing legal action. The client or parent whose attorney issues the subpoena must pay $500 in advance of a court appearance, which will be refunded if therapist is notified within three (3) days that the appearance is not needed.

Grievances: If you have a complaint/grievance, you should:

A. Notify a counselor of my grievance. If the grievance cannot be resolved at this informal level, the client shall request a conference with the Clinical Director. The counselor at this time will ask the client to put the grievance in writing.

B. The Clinical Director and the client will discuss the grievance within five working days.

C. The Clinical Director will attempt at this meeting to identify and dispose of any portion of the grievance, which represents misunderstanding of instructions, recommendations, requirements, policies, or practices.

D. However, if the client feels the action taken with the Clinical Director is not suitable, the client can request a conference with the Director (within five working days). The CEO shall provide the client, within 10 working days after their initial conference, a written statement summarizing the circumstances of the grievance and stating the decision as to its disposition. In lieu of a written statement, a second conference may be held and the decision stated. This conference, however, will be documented.

E. Each step must be documented and filed in client's chart.

F. Any Be Well Therapy, PLLC client has the right to file any grievance under the guidelines described above. It is hoped that any problem can be solved through a discussion between the client and primary case manager. Any corrective actions will not result in retaliation or barriers to client's service.

G. If the problem is still not resolved, the client may file a grievance with the PBS or the Disability Rights of North Carolina.

I understand that I have a right to contact the agencies below at any time to discuss my complaint or grievance:

NC Board of Licensed Professional Counselors
www.ncblpc.org
PO Box 77819
Greensboro, NC 27417
Ph: 844 622 3572

NC Division of Mental Health/DD/Substance Abuse Services
WWW. ncdhhs.gov/mhddsas
Advocacy and Customer Service Section 919.715.3197
DHHS CARE LINE: 1.800.662.7030

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I have carefully read, understand, and agree to comply with the above Office Policies and Consent for Treatment for psychotherapy service with Be Well Therapy, PLLC.

Client's Name (print)	Client's Signature	Date

Client's Name (print)	Client's Signature	Date

Therapist's Name (print)	Therapist's Signature	Date

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Insurance Coverage Worksheet

Date: _____

Client Name: _____

Date of Birth: _____ **SSN:** _____

Insurance: Y _____ N _____

Blue Cross and Blue Shield Y ____ N _____ **If yes, ID #:** _____
NC Healthchoices Y ____ N _____ **If yes, ID #:** _____
NC Medicaid Y ____ N _____ **If yes, ID #:** _____
Tricare Y ____ N _____ **If yes, ID #:** _____
Self-Pay Y ____ N _____ **If yes, amount:** _____
Policy ID#: _____

Policy Group #: _____

Employer Name: _____

Policy Holder Name: _____

Policy Holder SSN: _____

Relationship to Client: _____ **Sex: M ___ F ___ Date of Birth:** _____

Insurance Company Address: _____
_____

Insurance Provider Telephone: _____

Insurance Customer Service Telephone: _____

Insurance Authorization Number: _____

OFFICE USE ONLY

Insurance Copay _____ Insurance % _____ Client % _____
Insurance Deductible _____ Deductible Met: _____

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Insurance Reimbursement Rate _____# of Approved Sessions _____

Licensed Professional Counselors
AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF INFORMATION

I, _____ authorize **Be Well Therapy, PLLC** to disclose/use/release/exchange specified information from my medical records regarding services to/from: (Identify specifically to whom authorization for disclosure is granted-include, when available , name, address, phone number, fax number and to whose attention)

_____ _____ _____
(Client Name) (Client ID#) (Date of Birth)

as identified below to: _____

_____
(Name, Address, Title, Telephone Number)

Information to be released is identified as follows (place ***x*** beside item(s) to be released)

_____Discharge Summary
_____Physical Examination
_____Psychological Evaluation
_____Psychosocial Evaluation
_____Nursing Assessment
_____Recreational Assessment
_____Vocational Assessment
_____Psychiatric Assessment
_____Alcohol & Drug Information
_____Treatment Plan(s)/Reviews
_____Physician Progress Notes
_____Interdisciplinary Progress Notes
_____Physician's Orders
_____Laboratory Data
_____Educational Assessment
_____HIV Infection, AIDS or AIDS Related Conditions
_____Other (please specify): _____
_____

Purpose of Disclosure: **For treatment planning and follow-up services**

Expiration: □ One year from the discharge date **OR** □ Expiration Date or Event:_____

I understand that:

- I have the right to review the information that is being used or disclosed.
- The information being released may be subject to re-disclosure. The information will continue to be protected under the Health Insurance Portability and Accountability Act (HIPAA) if re-disclosure is to another covered entity (health provider, health plans, health care clearinghouses). The information will not continue to be protected under HIPAA, but may be subject to other privacy laws or policies if the re-disclosure is made to a non-covered entity. Be Well Therapy, PLLC is not responsible for any disclosure made by the institution authorized to receive this information.
- I have the right to refuse to sign this authorization form and, by doing so, refuse to allow the use or disclosure outlined above.
- I may revoke this authorization at any time by writing to Be Well Therapy, PLLC. However Be Well Therapy, PLLC may rely on this authorization until it receives written notice that I am revoking it.
- Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on obtaining this authorization.

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Federal Law 42 CFR Part 2 protects the confidentiality of drug and alcohol abuse patient records maintained by this facility. By my signature, I am authorizing disclosure of this information, if applicable.

Once information is disclosed pursuant to this authorization, I understand the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency disclose mental health and developmental disabilities information protected by state law (G.S.122C) or substance abuse treatment information federal law (42 C.F.R. Part2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Privacy Notice describes the circumstances where disclosure is permitted or required by these laws. I understand that the information to be released may include information regarding drug abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments.

_____

Client/Legal Guardian/In Loco Parentis Date

_____

Witness Date

Attach a copy of the appropriate legal document granting authority if signed by a Personal/Authorized Representative. Any disclosure of protected health by the recipient is prohibited except when implicit in the purposes of this disclosure.

I, the undersigned, do hereby exercise my right to REVOKE this Authorization to Use or Disclose Protected Health Information as described above in its entirety. This revocation does not apply to information, which may have previously been used or disclosed prior to the date below. I further understand that by this revocation, any future uses or disclosures of protected health information by Be Well Therapy, PLLC will require the completion of a new and separate Authorization to Use or Disclose Protected Health Information.

_____

_____

Signature of Client/Legal Guardian/In Loco Parentis Date

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_____

_____

Signature of Client/Legal Guardian/In Loco Parentis Date

PROGRAM PARTICIPANT'S RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

Name: Insurance ID#: DOB:

Every program participant at Be Well Therapy, PLLC has human/civil/personal rights to be respected and honored. In addition, it is the responsibility of all program participants to act in a manner that respects the rights of others. BE WELL THERAPY, PLLC is committed to the protection of individual rights and to providing services within an environment that is characterized by dignity and respect of all persons, and is responsive to the unique needs, abilities, and characteristics of each person served by the organization.

Program Participant Rights: As a participant in programming of BE WELL THERAPY, PLLC, you have the right to:

- Be fully informed about the course of your care and decisions that may affect your treatment
- Revoke your consent for treatment at any time
- Timely and accurate information to assist you in making sound decisions about your treatment
- Be fully involved as an active participant in decisions pertaining to your treatment
- Have an individual identified in writing that will direct and coordinate your treatment
- Request a change in individual directing and coordinating our treatment, if you so desire
- Receive services in an environment that is free of all forms of abuse, including, but not limited to, (a) financial abuse, (b) physical abuse and punishment, (c) sexual abuse and exploitation, (d) psychological abuse including humiliation, neglect, retaliation, threats and exploitation, and (e) all forms of seclusion and restraint
- Have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations
- File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort

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● Have family members, friends or others involved in your treatment with your consent and approval

● Receive services that comply with all applicable federal and state laws, rules and regulations

● File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have or, does not adequately address any formal grievance you submit

● To request a transfer to another program if you believe you are not receiving care that is meeting your needs and preferences.

Name: Insurance ID#: DOB:

PROGRAM PARTICIPANT'S RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT
BE WELL THERAPY, PLLC

Program Participant Responsibilities: As a program participant of BE WELL THERAPY, PLLC you have the responsibility to:

● Refrain from all forms of physical violence or abuse toward other program participants, staff, or visitors

● Refrain from abusive language, disruptive behavior or overt sexual conduct

● Refrain from loitering outside the organization's facilities

● Refrain from bringing any type of weapon into the organization's facilities or property

● Refrain from bringing any illicit (illegal) drug or alcohol onto the organization's property

● Refrain from using illicit drugs or alcohol while participating in services provided by the organization

● Use tobacco only in designated areas

● Attend all services required by the organization to meet agreed upon goals.

● Notify any outside treatment provider (Physician, case worker, counselor, etc.) of participation in services, should your treatment impact, or compromise, the provision of those services

● Treat other program participants, staff, and visitors in a respectable manner.

Client/Legal Guardian/In Loco Parentis Signatures Date

Witness Date

GIVE COPY TO PROGRAM PARTICIPANT

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Welcome to our counseling center! We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us better understand your situation as well as how best to help you create and maintain solutions for your current situation. Please note: the information is confidential and will not be released to anyone without your written permission.

Today's Date: _____

Services Requested (Check all that apply):

___Individual adult ____Individual child ___Family ___Marital/Couple ____Group/Workshop

Client Name: _____

First Middle Last

Address: _____

City_____ State _____ Zip Code_____

Home Phone ( ) _____ Cell Phone ( ) _____

Email _____DOB: _____ Age _____

SSN: ____-____-____ **Insurance and Policy Number:** _____

Race: ___African-American ___Asian ___Caucasian ___Hispanic ___Indian ___Other

Marital Status: ___Married ____ Single ____Widowed ____Divorced _____Separated

 # Of Children_____ **Total # in household**_____

Highest Level of Education: _____ **Military Status:** ____ Yes ____ No

Employment Status: __Unemployed __ Employed __ Student __Retired __Homemaker

Primary Care Physician and Telephone Number: _____

Emergency Contact Person: _____**Relationship:** _____

Phone Number of Emergency Contact:_____

Legal Responsible Person (if client is a child):_____

Home Phone: _____ **Cell Phone:** _____ **Work:** _____

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Source of Stress: What are the primary concerns that bring you here?

_____

_____

_____

_____

What is the most important thing you think your therapist should know about these concerns?

_____

_____

_____

Struggles: Is anyone in the family struggling with the following? **Check all that apply**

___Parent/Child conflict	___Partner violence/abuse	___School failure
___Couple concerns	___Sexual abuse/rape	___Truancy runaway
___Anger issues	___Alcohol/drug concerns	___Fighting w/ peers
___Depression/hopelessness	___Loss/grief	___Hyperactivity
___Anxiety/worry	___Legal issues	___Bed Wetting
___Communication problems	___Eating Problems	___Isolate/withdraw
___Divorce adjustment	___Sexuality/intimacy	___Child abuse
___Remarriage adjustment	___Suicide thoughts/attempts	___Eating Concerns
___Job problems/unemployed	___Major life changes	___Other

How much are the issues checked above disrupting your life?

____ A minor disruption ____ Somewhat of a disruption ____ Overwhelming disruption

Have you ever participated in counseling of any type?

____Yes _____No

Have you ever been hospitalized for a psychiatric problem?

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____Yes _____No

Have you experienced any type of health concern over the last 2 years?

____Yes _____No If yes, please explain: _____

Do you want to hurt yourself? ___Yes, with thoughts only___Yes, with a plan___No

Do you want to hurt someone? ____Yes, with thoughts only___Yes, with a plan___No

Do you have friends? ____None ____Few ____Many

Are you taking any medications? __Yes, please list name, dosage, and doctor ___No

Medication	Dosage	Doctor

Please let us know about your family's background:

Estimated yearly household income: (Financial information is used for clients without insurance and to seek outside funding to keep counseling fees affordable)

___Under $10,000 ___$10,000-$19,999 ___$20,000-$29,999 ___$30,000-$39,999
___$40,000-$49,999___$50,000-$59,999 ____$60,000-$69,999 ___$70,000 and over

Religion: ___Christianity ___Jehovah's Witness ___Buddhist ___Muslim ___Other

Importance of religion to you/your family:

___Very important ___Somewhat important ___Not Important

What are your goals for counseling?

1.

2.

3.

INSURANCE, PRIMARY CARE PHYSICIAN AND REFERRING PSYCHIATRIST AUTHORIATION

I understand that if therapy is being paid for using insurance, Be Well Therapy will release any and all records pertaining to treatment to the insurance company, the primary care physician, or your referring psychiatrist electronically, or by mail if such disclosure is necessary for claim processing, case management, and coordination of

treatment or utilization review purposes. I hereby authorize payments for medical services rendered to myself to be made whether to me or on my behalf to Be Well Therapy. I understand that I am responsible for any amount not covered by my insurance.

Client/Legal Responsible Person Signature:_____

Thank you for taking the time to complete this form. This information will help us understand your situation better and will allow us to assist you in reaching your goals as quickly as possible.

CONSENT FOR TREATMENT, OFFICE POLICIES, & GENERAL INFORMATION

Consent for Treatment

I give Be Well Therapy, PLLC permission to conduct assessment, treatment, and/or diagnostic procedures for myself or for my family member. By signing this form, I understand the counseling and therapeutic treatment methods will be explained to me upon my request and subject to my agreement. I acknowledge that this consent is truly voluntary and is valid until revoked. I understand that I may revoke this consent at any time.

Client Name (please print): _____

If client is a minor, name of legal guardian: _____

_____

Client's Signature Date

_____

Parent/Legal Guardian/In-Loco Parentis Signature Date

___ _____

Therapist's Signature Date