



Proven Progress Counseling and Trauma Treatment, PLLC

4601 Lake Boone Trail, Ste 2D

www.provenprogresscounseling.com

Phone (919) 276-0626 Fax (844) 355-2247

Patient Information Sheet

Last Name _____ First Name _____ MI _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____

E-Mail Address: _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Sex: Male _____ Female _____

Occupation; _____ Employer: _____

Emergency Contact: _____ Phone: _____

Mental Health Insurance Coverage:

Insurance Company _____ ID# _____

Primary Policy Holder Information:

Name of Policy Holder _____ Relationship to Patient _____

Policyholder's SS# _____ Policy Holder's Date of Birth _____

Assignment and Release

I, undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Proven Progress Counseling and Trauma Treatment, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor/therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature

Date



Proven Progress Counseling and Trauma Treatment, PLLC

4601 Lake Boone Trail, Ste 2D

www.provenprogresscounseling.com

Phone (919) 276-0626 Fax (844) 355-2247

Welcome to Proven Progress Counseling and Trauma Treatment, PLLC. We are glad that you have made the decision to start taking steps to improve your life and that you have selected our agency to help you on this journey. Your first session will consist of an intake appointment, in which your therapist gets to know more about you and your goals for coming to therapy. Your therapist will then discuss your diagnosis with you and work with you to develop a plan of treatment.

EVIDENCED BASED THERAPY APPROACH

At Proven Progress Counseling and Trauma Treatment, PLLC, we specialize in using evidenced based therapy techniques in our work with clients. Evidenced based therapy is a term used to describe specific mental health therapy techniques that have been proven to be effective through rigorous scientific research. There are evidenced based therapy approaches to treat a wide range of mental health problems, such as depression, anxiety, and PTSD. Evidenced based therapies tend to be short term (3-6 month) approaches that are focused and goal directed. Therapy sessions tend to have a plan or agenda for each session and often involve learning new information or skills. Most evidenced based therapy protocols involve homework, with clients practicing skills in between sessions to get maximum benefit. Your therapist at Proven Progress Counseling and Trauma Treatment, PLLC, has been trained in multiple evidenced based therapy protocols and will discuss these options with you during treatment planning.

TREATMENT PLAN

After learning about your symptoms and your goals for treatment, your therapist will discuss the treatment options that would best help you meet your goals. You and your therapist will then develop a treatment plan to help guide your sessions as you move toward a happier, healthier you. You may ask any questions you like about this treatment plan. Treatment will not proceed without your agreement and commitment to the plan. You are encouraged to discuss any questions or concerns you have about your treatment plan or your progress at any point during your treatment.

HOMEWORK

It is important for you to know that coming to these treatment sessions alone is not going to be enough for you to get better. In order for you to get better, you will need to make some changes in your life. Making changes can often feel difficult or challenging. Change is the key to getting better! We will work with you to help you to identify changes you can make.

Just as with anything else in life that you want to get better at (such as sports, playing music, or even losing weight), you need to practice. The more you practice and keep trying to learn, the better your outcomes will be. Your treatment plan will likely include some assigned activities between sessions. These activities might include self-monitoring of thoughts, feelings or behaviors, behavioral tasks, or other activities. These activities are an essential part of your treatment and it is important that you understand these assignments and complete them consistently to get the most out of your treatment.

BENEFITS/RISKS OF THERAPY

The purpose of therapy is to help you move toward your goals and to help you feel better about yourself and your life. Therapy often leads to better relationships, improved self-esteem and reductions in feelings of distress. While

therapy may provide significant benefits, it may also pose risks. Therapy may stir up some uncomfortable thoughts and feelings, like sadness, guilt, and anxiety. Although many people experience significant improvements as a result of therapy, it is impossible to predict or guarantee what you will experience.

COSTS

The standard session fees are as follows: \$125.00 per intake session, \$100.00 per forty-five (45) minute individual therapy session, and \$125.00 per sixty (60) minute individual therapy session.

If you are using your health insurance to pay for therapy services, the session charges will vary based off the contracted rates set by your insurance carrier. You are responsible for paying all co-pay, co-insurance, and deductible amounts. Proven Progress Counseling and Trauma Treatment, PLLC will file a claim with your insurance carrier/third party payer.

Some insurance companies limit the amount of therapy sessions that are authorized for their members. If this is the case, you and your therapist will discuss how this could affect your treatment plan and make appropriate arrangements.

APPOINTMENTS

Treatment will consist primarily of 45-50 minute long sessions. Sessions will typically occur about every week at the beginning of treatment and then taper off as you progress in treatment. Because other patients are scheduled with your treatment provider throughout the day, appointments can rarely exceed the scheduled 50-minute limit. Arriving late will reduce the amount of time available for contact with your therapist during that visit. Consistent attendance at scheduled appointments is necessary to make best use of treatment.

Please provide 24-hour notice for cancelled appointments. Missed appointments or appointments cancelled with less than 24 hour notice will incur a \$30 no-show/late cancellation fee. This fee is not billable to insurance companies and will be need to be paid by you. If you miss an appointment due to illness and bring in a doctor's note, the no-show/late cancellation fee will be waived.

CONFIDENTIALITY

Proven Progress Counseling and Trauma Treatment, PLLC is dedicated to preserving your confidentiality and privacy. In general, all communication between you and your therapist is confidential and this confidentiality is protected by law. There are a few unusual circumstances in which your confidentiality cannot be maintained.

- If you present a clear danger to yourself and refuse to accept appropriate treatment, information will be released to authorities to protect you.
- If you communicate a threat of physical violence to an identifiable victim, information will be released to protect the potential victim.
- If there is a reasonable cause to believe that a child, disabled adult, or elderly person is being abused or neglected, there is a legal requirement to disclose this information to authorities.
- If a judge orders the disclosure of information or orders your therapist to testify in a legal matter, information relevant to this legal issue will be provided.
- If services are being covered by a third party payer, like your insurance carrier, Proven Progress Counseling and Trauma Treatment, PLLC may be requested to provide information to them. If you request it, a report of the information that is submitted to an insurer on your behalf can be provided to you.

- If Proven Progress Counseling and Trauma Treatment, PLLC needs to initiate a collection action for a client's failure to pay, financial information related to treatment may be disclosed, such as the nature of services provided, the dates of services, and the amount due for services.

These exceptions to confidentiality rarely arise. When they do occur, the information released will be limited in scope to what is necessary to provide the appropriate agency.

In all other circumstances, your information will only be shared after you have provided express written consent. If you have questions about this confidentiality policy and its exceptions, please discuss them with your therapist.

ELECTRONIC HEALTH RECORD

The laws and standards of this profession require that we keep treatment records. A summary of each of your therapy sessions will be entered into an Electronic Health Record to document the services provided during each session. You are entitled to examine and/or receive a copy of your records if you submit a written request.

The Electronic Health Record used by Proven Progress Counseling and Trauma Treatment, PLLC has a patient portal that you can utilize to manage your appointments and complete paperwork. You will be sent an email at the start of treatment to set up a Patient Portal account. This is a voluntary tool that you can use and is not required to continue treatment. The appointment reminders sent to you through the Electronic Health Record are fully compliant with privacy rules and regulations.

_____ I consent to receive email reminders of therapy appointments.

_____ I consent to receive text message reminders of therapy appointments.

_____ I consent to receive telephone reminders of therapy appointments.

EMERGENCIES

It is not possible to reach your therapist 24-hours a day in the event of a behavioral emergency. If you ever feel that your safety or that of others may be in jeopardy or if you feel that you need immediate support to prevent harm from occurring, **call 9-1-1 or go directly to the nearest emergency room**. If you are having thoughts of hurting yourself, you can also call 1-800-273-8255, the national 24-hour Suicide Prevention Lifeline. You may also reach out to Holly Hill Hospital's Response line at 919-250-7000.

CONTACTING YOUR THERAPIST

Your therapist is often not immediately available by phone, as your therapist does not answer the phone when in a session with another client. Please feel free to call your therapist and leave a message on her confidential voicemail. Your therapist will make every effort to return your call as soon as possible, usually within one business day. As email and text messages are generally not a secure method of communicating your confidential information, your therapist will not be communicating with you via email or text messages.

SOCIAL MEDIA/PUBLIC SETTINGS

In order to maintain your privacy and maintain healthy boundaries, your therapist will not engage in communication with you through social media. Also, if you see your therapist in public, outside of the counseling office, your therapist will only acknowledge you if you greet them directly so as to not violate your confidentiality.

COMMUNICATION

Open communication with your therapist is a critically important part of your treatment experience. Please feel free to open any topic of conversation with your therapist, including any questions or concerns about your treatment or your interactions with your therapist. Although it is rarely necessary, referral to a different therapist will be made if you find it difficult to work with your current therapist.

MEDICATION

Medication can sometimes be helpful in treating a variety of symptoms and disorders. It is acceptable, and sometimes preferable, to take prescription medications in conjunction with psychological treatment. Your therapist cannot prescribe medications, but can refer you to a medication provider who can assist you with medication evaluation and ongoing medication management.

ENDING TREATMENT

Ideally, the end of treatment is mutually agreeable to the client and therapist after you have met your treatment goals. However, you may choose to refuse treatment or end treatment at any time for any reason. You do not have to provide a reason or ask permission to end therapy. If you do choose to end therapy, it is preferred that inform your therapist so that we can bring closure to our work together. We can also discuss any referrals you may need to another agency or provider at that time.

As a therapy service, we also reserve the right to terminate therapy at our discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, or needs that are outside your therapist's scope of competence or practice. Certain behaviors are unacceptable and grounds for immediate termination of services. Such behaviors include violence, threat of violence, verbal aggression, verbal threats and/or intimidation, and/or inappropriate sexual advances. If we are to end treatment, we will provide you with referrals to another provider or service we believe to be appropriate.

Proven Progress Counseling and Trauma Treatment, PLLC, reserves the right to change the policies, practices, and procedures described in this document. You will be notified in writing of any significant changes.

I have read the above statements about my rights and responsibilities. I hereby give my informed consent to be assessed and treated at Proven Progress Counseling and Trauma Treatment, PLLC. I have discussed any concerns I might have about the above statements with a staff member at Proven Progress Counseling and Trauma Treatment, PLLC. I understand that this statement of consent is in effect for 12 months from the date below unless I wish to revoke it earlier.

Signature

Printed Name

Date

Therapist Signature

Date



Proven Progress Counseling and Trauma Treatment, PLLC

4601 Lake Boone Trail, Ste 2D

www.provenprogresscounseling.com

Phone (919) 276-0626 Fax (844) 355-2247

Notice of Privacy and Confidentiality

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you may identify you and may relate to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *National Association of Social Work Code of Ethics*. It also describes your rights regarding how you may gain access to and control your 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 that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, 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 and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant 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 of payment-related activities 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. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection. If you pay for services out-of pocket, you may request that your PHI related to those services not be disclosed to your health plan for payment or health care operations and we will accommodate that request.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

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 investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. 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 are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the 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.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if 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.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Christine Duffy-Gill, at Proven Progress Counseling and Trauma Treatment, PLLC at 4601 Lake Boone Trail, Ste 2D, Raleigh, NC 27607 or (919) 276-0626:

- **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 may charge a reasonable, cost-based 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 to your 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 at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Christine Duffy-Gill, at Proven Progress Counseling and Trauma Treatment, PLLC at 4601 Lake Boone Trail, Ste 2D, Raleigh, NC 27607 or (919) 276-0626 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is January 1, 2019.



Proven Progress Counseling and Trauma Treatment, PLLC

4601 Lake Boone Trail, Ste 2D

www.provenprogresscounseling.com

Phone (919) 276-0626 Fax (844) 355-2247

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices.

Printed name of client

Signature of client

Date

Signature of Provider

Date

This form will be retained in your medical record



Proven Progress Counseling and Trauma Treatment, PLLC

4601 Lake Boone Trail, Ste 2D

www.provenprogresscounseling.com

Phone (919) 276-0626 Fax (844) 355-2247

Financial Responsibility Agreement

All co-pay, co-insurance, and deductible amounts are due on the date of service. I understand that I am responsible to provide my insurance card at Proven Progress Counseling and Trauma Treatment, PLLC, and that I am granting permission to bill my insurance company. This agency will collect the estimated amount (deductible, copay or coinsurance) when services are rendered and then charge for services to the insurance carrier or third party payer. I understand I'm responsible for any denied or outstanding balance upon insurance/third party reimbursement.

A \$30 late cancellation fee will be charged to the credit or debit card on file on the date of service if I miss an appointment without giving 24 hour notice to cancel or do not show up to a scheduled appointment.

A \$25 fee is charged for any credit or debit card decline or bounced check.

I understand if I default on any payment obligations as called for in this agreement, Proven Progress Counseling and Trauma Treatment, PLLC will have the right to forward my information to collections. I agree to pay all costs of collection, including, but not limited to, collection agency fees, court costs and attorney fees.

I, undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Proven Progress Counseling and Trauma Treatment, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature

Printed Name

Date

Credit Card Information

Name on Credit/Debit Card: _____ Billing Zip Code for Card _____

Credit Card Type: Visa _____ Mastercard _____ Discover _____ American Express _____

Card Number: _____ Expiration Date _____

CVV (3 Digit Number on Back of Card): _____

I acknowledge that I have been informed, understand, and agree to the above billing policy. I understand that payments are due on the date of service. I agree that Proven Progress Counseling and Trauma Treatment, PLLC may bill the credit card on file for any payments which are my responsibility that have not been paid for on the date of service. I hereby consent for Proven Progress Counseling and Trauma Treatment, PLLC to utilize my credit card information for any outstanding balance.

Signature of Credit Card Holder

Date Signed