INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: ____

(Last) (First) (Middle Initial)

Name of parent/guardian (if client is under 18 years):

____

(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ Age: ____ Gender: Male ☐ Female ☐

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age:____

Address: ____

(Street and Number)

____

(City) (State) (Zip code)

Home Phone:______________________ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone:______________________ May we leave a message? ☐ Yes ☐ No

Email:________________________________ May we email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes, previous therapist/practitioner: ____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that maybe requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____
Client Signature (Client's Parent/Guardian if client is under 18)

____
Today's Date

FINANCIAL STATEMENT OF UNDERSTANDING

This statement of understanding is intended to answer questions you may have regarding payment for services rendered by DRG Counseling.

PAYMENT FOR SERVICES:

We work with a number of insurance companies via managed care contracts and we will assist you in filing any insurance claims or forms which may be utilized for payments for services rendered; however, you maintain full responsibility for paying all charges for services rendered. You will need to provide all required insurance information when checking in for services; all primary, secondary, and/or co-insurances must be identified at the initial session and any changes in insurance information must be reported to the office for filing. You accept all financial consequences if all insurance policies are not identified, and you will need to update any insurance information immediately upon the date of change. All payments, co-payments, co-insurance and unsatisfied deductibles are to be paid at the time services are rendered. Therapist reserves the right to charge their session rate under the following circumstances: returning phone calls to clients and their attorneys, completing affidavits, writing letters on behalf of clients, etc. Account balances are due on date of service; we allow 60 days from the date of service for your insurance(s) to pay. Beyond 60 days, unpaid account balances are the client responsibility. Any balance greater than 90 days will be submitted to a professional collection agency unless payment arrangements have been made.

CANCELLATIONS:

If you cancel your scheduled appointment less than 24 hours prior to the scheduled session, you will be charged a $40 late cancellation fee which must be paid before the beginning of your next session. Monday appointments need to be cancelled by noon on Friday. To cancel an appointment scheduled on the day after a holiday, it needs to be cancelled on the day prior to the holiday. If you miss an appointment without giving any notice at all, you will be charged the full session fee, which must be paid prior to the beginning of your next session. Insurance will not cover broken/missed appointments. Failure to show for a total of 3 scheduled sessions without proper notification will lead to an administrative discharge from treatment.

INSURANCE COVERAGES:

Your Clinician's Participation with your Insurance Plan: Our agency accepts a wide variety of insurance plans. Prior to your initial visit with our agency, you should confirm that the clinician participates with your personal insurance. If the clinician does not participate with your insurance plan, you will be responsible for payment of all charges at the time of visit. You will be provided a complete superbill, upon request, listing all the pertinent information you will need to submit to your insurance plan for reimbursement for which you may be eligible.

Current Insurance and Client Demographic Information: If your therapist participates with your insurance plan, we may file a claim on your behalf and only request payment at the time of service for any co-payments, deductibles, coinsurance or services that are not covered by your plan. For the agency to file your insurance, we must have the current insurance coverage(s) and be made aware of any changes in either insurance or client address or phone numbers. Please bring your insurance card to every visit so that we can confirm your coverage. A current copy of your card must be kept on file for us to file insurance claims on your behalf.

Client Payment Responsibility for Non-Covered Services: In some cases, your insurance may not cover certain services or may have coverage limits in place. Limited coverage is common among insurance plans. We may request payment for any known, non-covered services at the time of your visit; otherwise they will be billed to you at a later date.

Medicaid Clients: Medicaid clients must show proof of current North Carolina Medicaid eligibility prior to receiving services. Further, I understand that if I change Medicaid types/MCO's (i.e., Alliance, Cardinal), I must notify DRG Counseling immediately. If I fail to do so, I understand that I will be responsible for the payment of all services rendered. Co-payments, if applicable, are to be paid at the time of service.

Signature of Client and/or Legal guardian.

Client/Guardian Name (Printed): ____

Client / Guardian Signature: _________________________ Date: ___________________

******<u>Disclaimer:</u>*******

<u>Please Note: During COVID-19, DRG Counseling will Accept forms filled out in Word and will Accept Full Client Name Written, in lieu of their signatures. This is a temporary situation, since we understand that many individuals might not have access to Printer and Scanner while working remotely. We are making this exception as a Good Faith Effort to accommodate Client needs during this time.</u>

Client Name: ____ DOB: ___________________

INFORMED CONSENT FOR TREATMENT

We are pleased that you have selected DRG Counseling, Inc. to work with you. This letter serves to inform you about the therapeutic treatment process, give you some information and answer questions about the professional relationship between the DRG Counseling therapist, clinicians and clients. We have several client expectations about the professional relationship we embark on with each client.

CONFIDENTIALITY: Confidentiality is an important part of the mental health/addictive disease treatment/therapy process. It means that unless you give us written permission, we may not give any information about you to anyone outside of DRG Counseling. If you and another adult (someone 18 years of age or older) are seen together, BOTH of you must agree in writing before any information can be released. There are specific times; however, when the law requires us to give information about you with or without your consent;

1. When required by subpoena or court order
2. To report known or suspected instances of abuse, exploitation, or neglect of children and elders
3. To warn another person that you have threatened his or her life
4. When you are a danger to your own life

RISKS AND BENEFITS OF THERAPY: While mental health/addictive disease therapy can be an effective mode of treatment for a variety of life problems, positive results cannot be guaranteed. One major benefit that can be gained from participating in treatment/therapy includes a better ability to handle or cope with family and other interpersonal relationships. Other benefits relate to the potential to resolve specific concerns brought to treatment/therapy. Seeking to resolve issues between family members and other person can similarly lead to discomfort, frustration, and relationship changes not originally intended. DRG Counseling clinicians focus on the relational nature of therapeutic problems. At any time, you may ask your clinician(s) to explain more about how they work, why they are gathering information, or why they are prescribing a specific approach.

PAYMENTS & CANCELLATIONS: Payment is due at the beginning of each session. We accept cash, personal checks and credit cards. We work with a number of insurance companies via managed care contracts and we are responsible for filing claims for our services to insurances, who we are credentialed with; you must pay your insurance copay or co-insurance amount at the time of services are rendered and any remaining balance towards your annual deductible. There are no exceptions. Other insurance plans (out of network) are accepted but you may be required to pay the difference between what is paid by the insurance and our normal rate. Payment arrangements are billed according to the amount of time utilized with a minimum fee of $25. This would include correspondence. We do not charge for customary insurance filing. Telephone consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour. Returned checks will incur a $35 returned check fee. It is necessary to give your clinician or the DRG Counseling administrative staff at least 24 hours advance notice if you need to cancel or reschedule an appointment. If you give less than 24 hours advance notice, you will be charged $40 Cancellation fee. However, for same day cancellations or No-Shows, you will be charged the full session fee, which must be paid prior to the beginning of your next session. Insurance will not pay for broken/missed appointments. Failure to show for 3 consecutive sessions without proper notification will lead to administrative discharge from treatment.

LEGAL SERVICES & COURT TESTIMONY: If your involvement in any legal matters leads to any DRG Counseling clinician being subpoenaed or court ordered to appear in court on your behalf, you will be charged a minimum of $250.00 per hour for the time that the clinician spends preparing to testify, travel to and from court, waiting to appear, testifying, depositions, attorney correspondence/communication affidavits, etc. You are responsible for and agree to pay these charges regardless if the clinician ultimately does or does not testify. An initial five-hour retainer is required to be paid prior to the court date.

EMERGENCY PROCEDURES: If you are in a life or death emergency, dial 911 for assistance or go immediately to your local emergency department. You can reach our therapist on call by calling our main number (919-977-6018) or call the Wake County Crisis & Assessment at Wake Brook Stabilization center at (984) 974-4800 for any mental health emergency.

COMPLAINT RESOLUTION PROCEDURES

The staff of DRG Counseling wants to know that you are satisfied with your individualized program. We also understand that with any ongoing relationship, there may be times of conflict. It is important to all of us that you feel your complaints or concerns are heard. The following is a guideline and timeframe for filing complaints. The first person to call should I have any problem with my fellow participants or programs staff is my therapist. I should expect to have he/she help me resolve the conflict within two (2) business days. Should I feel uncomfortable bringing my concerns to my therapist or feel that the situation has not been resolved to my satisfaction, I can contact my clinician's supervisor at the DRG Counseling main line at (919) 977-6018. I can expect this situation to be resolved within five (5) business days. Again, we believe that in working together to address conflict and concerns can only serve to help you reach your goals in your treatment plan through the services that are provided by DRG Counseling.

MANDATED REPORTING STATEMENT

As required by our regulatory agencies, the following information is provided:

1. DRG Counseling does not support nor condone the use of corporal punishment at any time.
2. Under state law, all supervisors, therapists, contractors, and employees of DRG Counseling are mandated reporters of child and elderly abuse and neglect. That is, we are required to make a report to the appropriate county office of the Department of Family and Children Services or related department when there is reasonable cause to believe that an elderly person or a child under the age of 18 years old has had physical injury inflicted upon him or her by a parent/caretaker by other than accidental means, has been neglected or exploited by a parent/caretaker or has been sexually assaulted or sexually exploited.

Please Read and Sign Below:

- I have read and understand the above statement concerning the limits of confidentiality, the risks and benefits of therapy, payment and cancellation policy, and emergency procedures. I do hereby seek and consent to take part in treatment provided by DRG Counseling. I understand that if payment for the services I receive is not made, the clinician may stop treatment. My signature below indicates my informed consent to receive services and reflects that I understand and agree with all the above statements. I have been given the opportunity to ask questions regarding this information.
- I understand that the fees for services are payable at the time of service and it is my responsibility to pay any deductible amount or co-insurance. I understand that I am financially responsible for all charges whether paid by insurance or not.
- I understand that at no point shall a person under the age of 14 be left unattended in any waiting areas. DRG Counseling's staff are not responsible or liable for any person left in the waiting areas.
- I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged the cancellation or session fee for that appointment.
- I acknowledge I have received a copy of Client Rights & Responsibilities, received an orientation of services, and give my voluntary consent for treatment
- I acknowledge I have received the Notice of Policies and Practices to Protect the Privacy of Your Health information. I acknowledge that I was provided a copy of the "Notice of DRG Counseling's Policies and Practices to Protect the Privacy of your Health Information" and that I have read (or had the opportunity to read if I so choose again).
- Informed Consent: By affixing my signature to this form, I acknowledge that I have read, understood, and agreed to all the policies detailed above and in the Notice of DRG Counseling's Policies and Practices to Protect the Privacy of your Health Information. I consent for my therapist to disclose PHI to my insurance company or PCP if required for payment of claims.

A staff member of DRG Counseling has reviewed the forms with me and I have received a copy of each form. I have had the opportunity to ask questions regarding these forms/policies.

Client Signature:____ Date:__________________

Parent/Legal Guardian Signature:____ Date: ______________

DRG Counseling

5720 Creedmoor Road, Suite 201 | Raleigh, NC 27612 | Phone: 919.977.6018|
Fax: 919.300.7471
Website: www.drgcounseling.org

Effective October 1st 2020, DRG Counseling will begin fully enforcing our Cancellation Policy and Card on File Policy. There will be a $75 fee for all No-shows/Missed appointments or appointments cancelled with less than 24 hour notice. We will now be storing all credit cards on file, which will be charged automatically for sessions attended and/or sessions not covered by Insurance, cancellations, no-shows. Please note that this information will not be shared with anyone outside of DRG Counseling Administration. An email receipt will be sent if and when credit card is charged. DRG reserves the right to cancel an upcoming appointment if the following information is not acquired prior to the sessions, in a timely manner. Please provide the following information to store your card on file.

Name on Card: ___________________________________

Credit Card No. # : ____

Expiration date:_________________

CVV: _____________________

Billing Zip-Code: _________________________________

E-Mail: ____

Thank you for your consideration and for valuing the time of our Clinical Staff. We truly appreciate it.
Please Read and Sign below to acknowledge receipt of this information.

____
Print Name & Date

____
Signature