YOU-Turn Counseling, PLLC

108 S. Ellington St.
Clayton, North Carolina 27520

Office: 919-585-2282
Fax: 919-879-8357

Client Services Agreement

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment, directly to YOU-Turn Counseling, PLLC of insurance benefits for provided services otherwise payable to me.

RESPONSIBILITY FOR PAYMENT: I agree that I am responsible for the total balance due on my account for services rendered by YOU-Turn Counseling, PLLC even though I may arrange for my health care plan to pay for part of it. I agree to allow YOU-Turn Counseling, PLLC to use my credit card information that I provide for the purpose of paying off unpaid balances on my bill. It is my responsibility to inform YOU-Turn Counseling, PLLC of my current address, phone number, and any change to my credit card information until my final balance is paid in full.

CO-PAYMENTS: Co-payments are due in full at the time service is rendered. Cash, Check, or credit card will be accepted.

DEDUCTIBLES: I understand that although I may arrange for my insurance to pay for the service that reimbursement by my insurance company to YOU-Turn Counseling, PLLC will not be made unless my deductible is met in full. If my deductible is not met in full I agree that I will pay YOU-Turn Counseling, PLLC the full balance for service rendered.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Since I will be reserving appointment times in advanced at YOU-Turn Counseling, PLLC. I also agree to pay a $50 fee for any scheduled appointment that I either miss or cancel with less than 24 hours prior notice. If I have Medicaid or Healthchoice, I agree to pay a $20 fee for any scheduled appointment that I either miss or cancel with less than 24 hours prior notice. I understand that with less than 24 hour notice to cancel an appointment, YOU-Turn Counseling, PLLC would likely lose revenue through unfulfilled appointment times and fellow clients are without the opportunity to utilize my open appointment time. **TWO OR MORE LAST MINUTE CANCELLATIONS MAY RESULT IN BEING INELIGABLE FOR RESCHEUDLE OR CONTINUED SERVICES. IT IS AT YOUR PROVIDER'S CLINICAL DISCRETION TO CONTINUE TO PROVIDE SERVICES OR YOU MAY BE ASKED TO SEEK A NEW SERVICE PROVIDER.**

SECURITY ARRANGEMENT: It is the policy of YOU-Turn Counseling, PLLC to obtain security in the form of your credit card authorization to conveniently pay for possible charges that will not be covered by your insurance carrier. These possible charges include unanticipated missed appointments, late cancellations, charges for insufficient funds for checks or credit card payments, unmet deductibles, and insurance company UCR discrepancies from the actual fees. Regular co-payments will be made at each session and you will be able to choose your method of payment for those. All credit card information will be stored securely and confidentially.

INFORMED CONSENT: I have had explained to me and I understand the counseling service to be provided. This description has included an explanation of the services provided, the limits of the service, and possible consequences of counseling. I have had the opportunity to ask questions and receive acceptable and understandable answers. I am availing myself of this service voluntarily and with knowledge of its benefits and limitations.

The following credit card information is required:

Full Name on card (print):_____ Card #:_____

Billing Address: _____

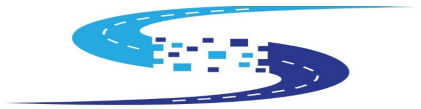
Email Address (for receipt only): _____

Expiration date: _____ Circle: VISA or MASTERCARD CVC Code _____

By signing below, I am indicating that I agree to the above. I also attest that with this financial service contract, I have been given a copy of "Notice of Policies and Practices to Protect Privacy of your Health Information" as is required by law.

Agreed: _____

Patient Signature or Responsible Party (if not patient) Date



LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a therapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or North Carolina Law. However, in the following situations, no authorization is required:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. These other professionals are also legally bound to keep the information confidential. Unless you object, we will only tell you about these consultations if we feel that it is important to our work together. All consultations will be noted in your Clinical Record (which is called "PHI" in our Notice of Policies and Practices to Protect the Privacy of Your Health Information).

- We practice with other mental health professionals and we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All administrative staff have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. You have the right to restrict the disclosure of PHI to your insurance company if you pay for services in full.

- We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer. Use and disclosure of your PHI for marketing purposes and the sale of PHI is not allowed without your written authorization.

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. We cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, consult with your attorney to determine whether a court would be likely to order us to disclose information.

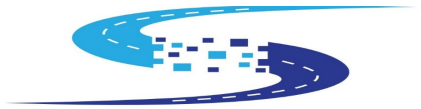
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against us, state law permits us to disclose relevant information regarding that patient in order to defend ourselves.

There are some situations in which we are legally obligated to take actions that we believe are necessary to protect others from harm and in which we may have to reveal some information about a patient's treatment. These situations are unusual in our practice, but they include:

- If we have reason to suspect that a child or vulnerable adult has been subjected to abuse or neglect, or that a vulnerable adult has been subjected to self-neglect or exploitation, the law requires that we file a report with the appropriate government agency, usually the local office of the Department of Social Services. Once such a report is filed, we may be required to provide additional information.

- If we know that a patient has a propensity for violence and the patient indicates that he/she has the intention to inflict imminent physical injury upon a specified victim(s), we may be required to take protective actions. These actions may include establishing and undertaking a treatment plan targeted to eliminate the possibility that the patient will carry out the threat, seeking hospitalization of the patient, and/or informing the potential victim or the police about the threat.



- If we believe that there is an imminent risk that a patient will engage in potentially life-threatening behaviors or that immediate disclosure is required to provide for the patient's emergency health care needs, we may be required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action, and we will limit the disclosure to what is necessary.

While this written summary of exceptions to confidentiality aims to inform you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we in situations where specific guidance is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record if you request it in writing. In unusual circumstances in which disclosure is reasonably likely to endanger the life or physical safety of you or another person, we may refuse your request. In those situations, you have a right to a summary and to have your record sent to another mental health provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, the State of Maryland permits a copying fee and certain other expenses. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include: requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you. For more information, you can also visit http://www.hhs.gov/ocr/privacy/index.html.

MINORS & PARENTS

It is important for patients under 18 years of age who are not emancipated and their parents to be aware that the law may allow parents to examine their child's treatment records. However, because privacy in psychotherapy is very important, particularly with teenagers, we usually ask parents to respect the child's privacy and allow for the therapist and minor to keep elements their interactions in confidence, though not any related to danger to the child (see Limits on Confidentiality). On the other hand, because parental involvement in therapy is essential to successful treatment, we are always willing to share with parents general information about the progress of treatment and their child's attendance at scheduled sessions. Parents may also request an oral summary of their child's treatment when it is complete. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

PLEASE RETAIN THIS DOCUMENT FOR YOUR PERSONAL RECORDS