Triad Counseling & Clinical Services, LLC
5587 D Garden Village Way
Greensboro, NC 27410
336-272-8090 Office 336-272-0094 Fax

High Point Location – Karen Elliott
232 Woodrow Ave
High Point, NC 27262
336-882-2812 Office 336-882-8632 Fax

Rev 01/01/2018

CLIENT UPDATE SHEET

Please Print

Date:________________________

Client Name:________________________________( ) M ( ) F ( ) Gender __________

Date of Birth: Mo____Day____Year_______Social Security #_______-______-________

Parent/Guardian Name:(If client is under18)____

Address: ____
Street

________________________ ______________ _________________
City State Zip

Consent to contact by email: Y / N Email address:______________________________

Phones: Home________________Work_________________Cell _________________

Consent to leave messages at numbers listed above: __Home___Work___Cell (check all that apply)

Select One (1) Method for appointment reminders: ( ) Voicemail (___)______________
( ) Email_________________________( ) Text (___)____________________________
( ) No Reminder Necessary

Who may we contact in an emergency?

______________________________ _________________________ _______________
Name Relationship Phone

Should this office file insurance for you?______yes______no Please present card if yes.

INSURANCE AND PAYMENT INFORMATION
All professional services rendered charged to the client. I understand that this office files my insurance as a courtesy but the bill is my responsibility. I am responsible for all fees, including services not covered by insurance, unless expressly noted otherwise. It is customary to pay for services when rendered unless arrangements are made in advance**. I UNDERSTAND THAT APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS WILL BE CHARGED THE FULL FEE. I UNDERSTAND THAT THIS IS NOT BILLABLE TO MY INSURANCE COMPANY**.

_______________________________________ ______________________________
Signature Date

This authorization shall remain in effect for one year unless otherwise specified._______________(mm/dd/yyyy)

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Release of Information
Scheduling or Billing

You can authorize the release of your private health information to others for scheduling or billing purposes. Keep in mind that we cannot discuss your records without your written consent. Please complete the section below if you would like to allow access to your records.

☐ I **do not authorize** access to my private health information (PHI) at this time.

OR

☐ I **authorize** access to my private health information (PHI) to the following individual:

Name:____,

Relationship:____________________________, in the following forms and purposes only:

_______Scheduling (making, changing, or verifying appointments)

_______Billing (accessing verbal and written detailing in regards to payments, session dates, and general billing inquires, including allowing others to make payments on my behalf)

____
Printed Client Full Name

____
Client's Signature (or Parent/Guardian) Date

This authorization shall remain in effect for one year unless otherwise specified. _________________(mm/dd/yyyy)

Triad Counseling and Clinical Services, LLC
5587-D Garden Village Way, Greensboro, NC 27410
232 Woodrow Avenue High Point, NC 27262

CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information" or PHI), excluding psychotherapy notes, by Triad Counseling and Clinical Services, LLC (Provider) in order to carry out treatment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except in special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my medical/mental health records, although I understand the Provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a "reviewing official." A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my medical/mental health records, although I understand the Provider has the right to deny such request. I have the right to request an accounting of disclosures of my PHI for purposes other than TOP and those for which I provided authorization. I may submit a written privacy complaint to 5587 D Garden Village Way. Greensboro, NC 27410 or to the U.S. Secretary of the Department of Health and Human Services, without any action being taken by the Provider against me without any change in my treatment.

Provider reserves the right to change the terms of its Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed, I may obtain a copy of the revised Notice by requesting a copy.

I retain the right to request that the Provider further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Provider is not required to agree to such requested restrictions; however, if the Provider does agree to requested restriction(s), such restrictions are then binding on the Provider.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Provider in writing. The revocation shall be effective *except* to the extent that the Provider has already taken action in reliance on the Consent.

The Provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the Provider is required by law to treat individuals). If I (or authorized representative) sign the Consent portion and then revoke Consent, the Provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Provider is required by law to treat individuals).

I ______ HAVE HAD AN OPPORTUNITY TO REVIEW THE PROVIDER'S NOTICE OF PRIVACY PRACTICES.

I ______ **CONSENT** TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

OR

I ______ **DO NOT CONSENT** TO THE RELEASE FOR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

______________________________ ____ ________________

Please Print Name Client's Signature (or authorized representative) Date

Representative's Authority to act on behalf of the Patient: ____

This authorization shall remain in effect for one year unless otherwise specified. _________________(mm/dd/yyyy).

For office staff use only:
Acknowledgement of Privacy Practices was not obtained because: ____

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