Charlotte Center for Balanced Living

Client Information:

Name _____

Address _____

City _____ State _____ Zip Code _____ Gender _____

Date of Birth _____ Marital Status _____ Employer/School _____

Home Phone _____/ Cell Phone _____ ok to leave vm? _____

E-mail address _____

Please initial here if it is okay for Lanier Mayhew (office manager) and your provider to use ___

Name of referral source: _____

Appointment Reminders: (Choose 1 Option)

_____ via text message on my cell phone

_____ via email to address listed above

_____ via an automated telephone message to my home phone

_____ None of the above.

Appointments not canceled by the noon the business day prior to your appointment will incur a 75.00 charge. _____ (initial)

Appointment information is considered to be "Protected Health Information" under HIPAA. By signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature _____ Date_____

Insurance and Payment Information

Are you the insurance policy holder ? Yes / No (circle)

If no, please fill out below section:

Name

_____

Address

_____ _____ _____ _____

City State Zip Code Gender

_____ _____ _____

Date of Birth Marital Status Employer/School

Are you responsible party for payment? Yes / No (circle)

If no, please fill out below section:

Name

_____

Address

_____ _____ _____ _____

City State Zip Code Gender

_____/_____ _____

Home Phone Cell Phone ok to leave vm?

E-mail address _____

Please initial here if it is okay for Lanier Mayhew (office manager) and your provider to use ___

Which is the best form of communication with you? _____

Terms of Agreement

CONFIDENTIALITY: I understand that all client conversations and records will be kept confidential unless written permission is granted otherwise. However, state law requires therapists to report any suspected child abuse or any concerns that he/she may have regarding a patient's possible likelihood of harming him/herself or others. In some situations, a judge may order that records are required to administer justice in a case. Also, your case may be reviewed with another therapist in order to enhance the services you receive. Of course, if it becomes necessary to turn your account over to a collection agency, some confidentiality will be breached in the process as well.

I understand that Charlotte Center for Balanced Living follows the guidelines set by the Health Information Portability and Accountability Act. I also understand that I can request an accounting of disclosure of this information. I have been informed of the policies of the Charlotte Center for Balanced Living that can be ready on the website (www.charlottebalance.com) or provided in printed form upon request.

FINANCIAL RESPONSIBILITY: I understand that Charlotte Center for Balanced Living files claims with insurance as a courtesy, that ultimately I am responsible for the balance on my account for any professional services rendered. I understand that a 40% collections fee will be added to my past due account balance if it becomes necessary to turn my account over to a collection agency.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the attending therapist to release any information acquired in the course of my therapy to the insurance carriers involved in the payment of my account as well as to report to case managers as required by my managed care health plan if applicable.

ASSIGNMENTS OF BENEFITS: I hereby authorize payment directly to the attending psychologist/therapist (to be processed through the business of Charlotte Center for Balanced Living) for professional services rendered.

CONFIDENTIALITY AND PROTECTION OF PERSONAL INFORMATION

Charlotte Center for Balanced Living protects personal health information and confidential material according to the guidelines established by the Health Information Portability and Accountability Act. These guidelines, along with the ethical standards set by the American Psychological Association determine the handling of this information. The notice stating the specific privacy policy and practices, instructions for requesting accounting of any disclosures of this information, and restrictions on disclosures can be found on our website (www.charlottebalance.com). This same information will also be provided to you in printed form upon your request.

BILLING AND INSURANCE

Payment is full is expected at the time of your visit, unless prior arrangements (e.g. managed care health insurance) have been made with our office. Your payment may be made by cash, personal check, MasterCard or Visa.
Any insurance information given to you by our staff is not a guarantee – it is only an estimate. Please call your insurance company yourself for official information.

Please be aware that your balance may change once we receive a response from your insurance company for the claim filed. Our filing of an insurance claim does not relieve you of your responsibility for the account. Most insurance companies do not pay 100% of a claim, deductibles and co-payments usually apply.

75.00 CHARGE FOR MISSED APPOINTMENTS

WE REQUIRE APPOINTMENST TO BE CANCELED BY 12 PM THE DAY PRIOR TO YOUR APPOINTMENT. MONDAY APPOINTMENTS MUST BE CANCELED ON THE FRIDAY PRIOR TO YOUR APPOINTMENT BY 12PM.

Our office does not do "reminder calls" unless specifically requested, however this does not relieve you of the responsibility of the appointment.

EMERGENCIES AFTER OFFICE HOURS

If you have an emergency after our business hours and your need immediate response, please call the Behavioral Health Center @ 704-444-2400, or 1-800-418-2065. An emergency is usually treatment related; such as purging blood, feeling dizzy, irregular heartbeat, thoughts of suicide, or other medical complications. If you feel you cannot safely wait to speak with your therapist, go to the nearest emergency room or call 911. These directions are given to you on our recorded message.

Signature of responsible party Date

By signing as the person responsible for this account, I agree and understand the policies.