**Welcome to Carolina Developmental Behavioral Pediatrics, PLLC**!

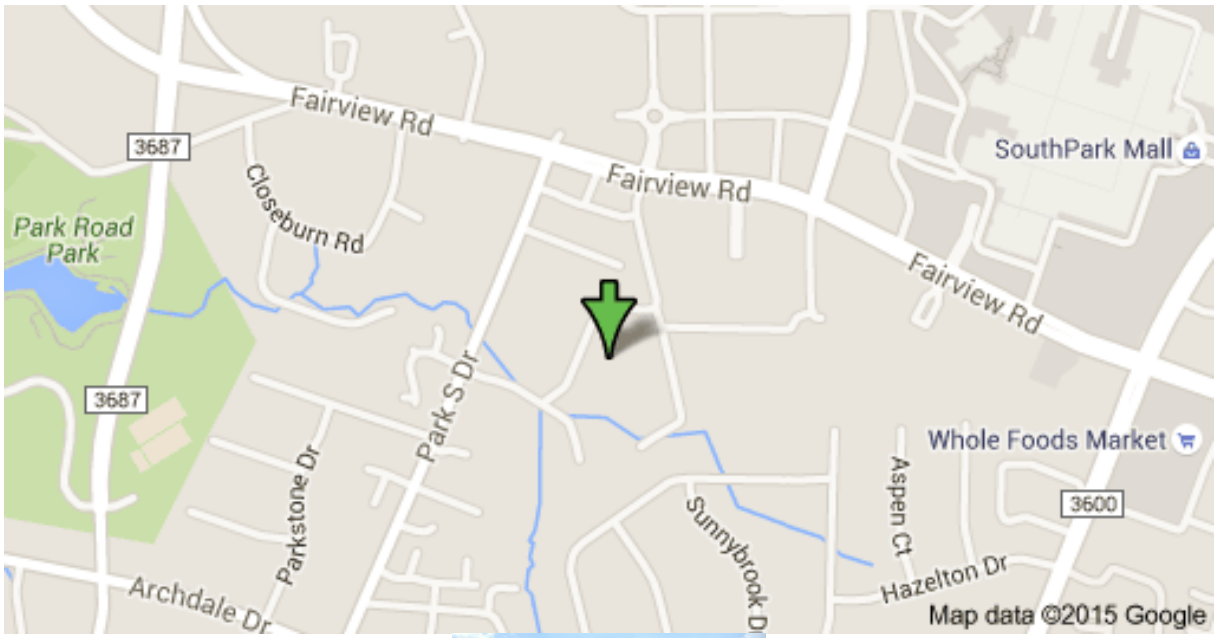
Thank you for scheduling an appointment with us. We are dedicated to providing you with a safe and helpful experience. To get started, we are enclosing some forms for you to read and complete.

Below is a map and picture of our South park office building at **6060 Piedmont Row Drive South, Suite 120, Charlotte, NC 28287**. You will also find an interactive map on our website at www.mentalhealthpeds.com. Please check out our website to learn about our practice and our staff. If you have any questions about directions or about our practice, please contact us at **980.785.2968**

We look forward to working with you!

Sincerely,

Carolina Developmental and Behavioral Pediatrics




Mental Health Peds

## *Client Information Registration*

| | |
|---|---|
| **Last Name:** | **Address:** |
| **First:** **Middle:** | **Apt. #:** |
| **Date of Birth:** **Age:** **M ☐ F ☐** | **City:** **State:** **Zip:** |
| **Marital Status:** **Single ☐ Married ☐ Divorced ☐** | **Home Phone:** |
| **SS#:** | **Cell Phone:** |
| **Employer/School:** | **Work Phone:** |
| **E-Mail:** | **Permission to contact by E-Mail:** **Yes ☐ No ☐** |
| | |
| **Insurance Company:** | |

## Parent or Guardian (if above is a minor) or Other Responsible Party

| | |
|---|---|
| **Last Name:** | **Address:** |
| **First:** **Middle:** | **Apt. #:** |
| **Date of Birth:** **Age:** **M ☐ F ☐** | **City:** **State:** **Zip:** |
| **Marital Status:** **Single ☐ Married ☐ Divorced ☐** | **Home Phone:** |
| **SS#:** | **Cell Phone:** |
| **Employer:** | **Work Phone:** |
| **E-Mail:** | **Permission to contact by E-Mail:** **Yes ☐ No ☐** |

## Referral Source

| | |
|---|---|
| **Name:** | **May we thank them?** **Yes ☐ No ☐** |
| **Company:** | **Phone #:** |
| **Address:** | |

## Appointment Confirmation

Our automated phone system will attempt to call to remind you of your scheduled appointment only if you have given us permission to do so and provided us with an accurate phone number. This courtesy does not alter your responsibility to give us 24-hour notice of changed or cancelled appointments to avoid being charged a late cancellation or no show fee.

| |
|---|
| **May we call you to confirm appointments: Yes ☐ No ☐** **Preferred Phone #:** |

# Terms of Agreement

Confidentiality: I understand that all client conversations and records will be kept confidential unless written permission is granted stating otherwise. State law requires that provider 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 records if required to administer justice in a case. Also, your case may be reviewed with another therapist in order to enhance the services you receive. Additionally, if it becomes necessary to turn your account over to a collection agency, some confidentiality will be disclosed for collection purposes.

I understand that Carolina Developmental and Behavioral Pediatrics, PLLC follows the guidelines of HIPAA. I also understand that I can request an accounting of disclosures of this information. I have been informed of the policies of Carolina Developmental and Behavioral Pediatrics, PLLC that can be read on the website or provided in printed form upon request.

Financial Responsibility: I have read the Business Policies of Carolina Developmental and Behavioral Pediatrics, PLLC and agree to those terms including that I am ultimately responsible for the balance on my account for any professional services rendered.

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**Signature of responsible party for the payment of this account** **Date**


# BUSINESS POLICIES

## CONFIDENTIALITY AND PROTECTION OF PERSONAL INFORMATION

Carolina Developmental Behavioral Pediatrics, PLLC protects personal health information and confidential material according to the guidelines established by the Health Information Portability and Accountability Act (HIPAA). 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.mentalhealthpeds.com). This same information will also be provided to you in printed form upon request.

## BILLING AND INSURANCE

Payment is due at the time the service is rendered. We accept cash, check and the following credit cards: MasterCard, Visa, and Discover. We are out-of-network with insurance companies. This means clinicians at Carolinas Developmental Behavioral Pediatrics, PLLC do not have contracts with health insurance carriers. Most individuals have out-of-network benefits with their health insurance plans. This gives you the option to receive services from providers outside of your healthcare network with possible reimbursement for covered expenses. By opting to use an out-of-network provider, you could have a higher deductible and the amount of reimbursement could be lower, depending on your plan. There are some plans that do not offer out-of-network benefits.

Since you are paying in full at the time of service, your insurance company will reimburse you. We will gladly give you the documentation needed to submit a claim to your insurance company. Your insurance policy is a contract between you and your insurance company so it is important for you to carefully check the benefits of your policy. You will need to call your insurance company to determine what your deductible is for outpatient mental health visits; what percentage of the allowable is reimbursable for each visit once the deductibles has been met; and, determine if the number of visits per year are limited. It is also important to ask if pre-authorization is required prior to coming for your appointment.

## CHARGES FOR MISSED APPOINTMENTS

A fee will be charged to your account for late cancellations and no shows. Insurance does not cover this type of charge. To avoid being charged a late cancellation and/or no show fee, we must have 24 hours' notice from you. We have a 24 hour answering service should you need to call after business hours to cancel. As a courtesy to you, our office does not "double book" clients for the same time slot. A specific time has been reserved just for you. Because of this, it is very important that you handle any cancellations properly. Our automated phone system will attempt to call to remind you of your scheduled appointment if you have given us permission to do so and provided us with an accurate telephone number. This courtesy does not alter your responsibility to give us 24 hours' notice of changed or cancelled appointments to avoid being charged a late cancellation and/or no show fee. Please note: After two late cancellations and/or no shows, you may be placed on our *Do Not Schedule* list.

## MISCELLANEOUS FEES AND CHARGES

**COLLECTIONS FEE:** A collections fee of 40% of your account balance will be added to your past due account if we are unable to obtain payment on your account and it becomes necessary to turn your account over to a collection agency to obtain payment. In the event of overpayment, a refund will be promptly made to the person responsible for the payment of the bill.

**RETURNED CHECK CHARGE:** A service charge of $25.00 will be applied to all returned checks. You will be required to pay cash or credit card to cover the amount of the returned check plus the service charge.

## AFTER HOURS EMERGENCIES

If you have an emergency after our business hours and require an immediate response, please call our after-hours line at 980.288.1434. Please call the telephone number provided and leave a detailed message and provider will respond as quickly as possible. An emergency is usually treatment related; other issues (i.e. appointment scheduling, cancellations, insurance/billing concerns, etc.) do not constitute emergencies. If you feel you cannot safely wait to speak with your provider, go to the nearest emergency room or call emergency services (911). These directions are given to you on our recorded message.

**UNDERSTANDING AND AGREEMENT WITH BUSINESS POLICIES**

*My signature below indicates that I have read and understood the Business Policies of Mental Health Peds.*

Client's Signature _____ Date _____

Signature of Parent/Guardian/Responsible Party _____ Date _____

**INFORMED CONSENT FOR ASSESSMENT AND TREATMENT**

| Client Name: | DOB: | Clinician: |
|---|---|---|

I understand that as a client of Carolina Developmental Behavioral Pediatrics, PLLC, I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks or months.

I understand that all information shared with clinicians at Carolina Developmental Behavioral Pediatrics, PLCC, Carolina Developmental Behavioral Pediatrics, PLCC, is confidential and no information will be released outside of without my consent. During the course of treatment at Carolina Developmental Behavioral Pediatrics, PLCC, it may be necessary for my provider to communicate with other providers at Southeast Psych, for the purpose of collegial support in order to provide me with the best possible care. Written authorization will not be requested for communications with other Southeast Psych providers unless you specify otherwise. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is a risk of imminent danger to me or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or disabled adult is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or disabled adult and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at Carolina Developmental Behavioral Pediatrics, PLCC, I may discuss them with my provider. I have read and understand the above and I consent to participate in the evaluation and treatment offered to me by Carolina Developmental Behavioral Pediatrics, PLCC. I understand that I may stop treatment at any time.

| Client Signature: | Guardian Signature: |
|---|---|
| Provider Signature: | Printed Guardian Name: |
| Date: | Date: |

# Carolina Developmental Behavioral Pediatrics, PLCC

**Notice of Carolina Developmental Behavioral Pediatrics, PLCC**
**Policies and Practices to Protect the Privacy of Your Health Information**

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

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

## I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Carolina Developmental Behavioral Pediatrics, PLLC (hereafter referred to as CDBP) may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

"*PHI"* refers to information in your health record that could identify you.

*"Treatment, Payment and Health Care Operations" - Treatment* is when CDBP provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when CDBP consults with another health care provider, such as your family physician or another psychologist. *Payment* is when CDBP obtains reimbursement for your healthcare. Examples of payment are when CDBP discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"*Use*" applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"*Disclosure*" applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

## II. Uses and Disclosures Requiring Authorization

CDBP may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when CDBP is asked for information for purposes outside of treatment, payment and health care operations, CDBP will obtain an authorization from you before releasing this information. CDBP will also need to obtain an authorization before releasing your medical notes. *"Medical notes"* are notes CDBP has made about our conversations during a private, group, joint, or family session, which CDBP has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) CDBP has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

## III. Uses and Disclosures with Neither Consent nor Authorization

CDBP may use or disclose PHI without your consent or authorization in the following circumstances:

**Child Abuse:** If you give us information which leads us to suspect child abuse, neglect, or death due to maltreatment, CDBP must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, CDBP must do so.

**Adult and Domestic Abuse:** If information you give us gives us reasonable cause to believe that a disabled adult is in need of protective services, CDBP must report this to the Director of Social Services.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding, and a request is made for information about the professional services that CDBP has provided you and/or the records thereof, such information is privileged under state law, and CDBP must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

**Serious Threat to Health or Safety:** CDBP may disclose your confidential information to protect you or others from a serious threat of harm by you.

## IV. Client's Rights Regarding Your Health Information

### Client's Rights:

*Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, CDBP is not required to agree to a restriction you request.

*Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, CDBP will send your bills to another address.)

*Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. CDBP may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, CDBP will discuss with you the details of the request and denial process.

*Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. CDBP may deny your request. On your request, CDBP will discuss with you the details of the amendment process.

*Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, CDBP will discuss with you the details of the accounting process.

*Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

### Changes To This Notice

CDBP is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

CDBP reserves the right to change the privacy policies and practices described in this notice. Unless CDBP notifies you of such changes, however, CDBP is required to abide by the terms currently in effect.

If CDBP revises our policies and procedures, CDBP will notify you in writing by mail within 30 days.

## V. Questions and Complaints

If you have questions about this notice, disagree with a decision CDBP make about access to your records, or have other concerns about your privacy rights, you may contact our office manager at 980.785.2968.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to our office manager at:

***Carolina Developmental Behavioral Pediatrics, PLLC***
***Attn: Office Manager***
***6060 Piedmont Row Drive South, Suite 120***
***Charlotte, NC 28287***

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. CDBP will not retaliate against you for exercising your right to file a complaint.

## VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 1, 2016 and will remain in effect until we replace it.

CDBP reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that CDBP maintains. CDBP will provide you with a revised notice by publishing the changes, posting these changes at CDBP and on our website (www.mentalhealthpeds.com).

### Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Client's Name: _____ Date: _____

Parent/Guardian/Responsible Party: _____ Date: _____