SECTION 1: CLIENT INFORMATION

Name .....
(Last) (First) (Middle)

Date of Birth ..... Social Security # .....

Mailing Address.....
(Number/Street)

.....
(City) (State) (Zip)

Telephone ....
(Home) (Cell) (Work/Other)

Status: ☐ Single ☐ Married ☐ Other

☐ Employed ☐ Student ☐ Other

HOW WERE YOU REFERRED TO INTEGRATED THERAPY ASSOCIATES: .....

SECTION 2: PRIMARY INSURED'S INFORMATION - Complete if you are using insurance and you are <u>NOT</u> the primary on the policy. If you are the primary insured then it is not necessary to complete this section; however, we do require your signature on both lines at the bottom of the page.

Insured's I.D. # ..... Insured's Policy Group or FECA # .....

Insured's Name .....
(Last) (First) (Middle Initial)

Insured's Date of Birth ..... Sex ..... Insured's Telephone .....

Insured's Address .....
(Number/Street)

.....
(City) (State) (Zip)

Insured's Employer/School ..... Insurance Plan/ Program Name .....

Client's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Is condition related to: ☐ Employment (current or previous) ☐ Auto Accident ☐ Other Accident

Is there another Health Benefit Plan? ☐ Yes ☐ No

SECTION 3: PARENT/GUARDIAN INFORMATION - Complete if client is a minor (under age 18).

Parent/Guardian Name .....
(Last) (First) (Middle)

Address .....
(Number/Street) (City) (State) (Zip)

Telephone ....
(Home) (Work) (Other)

Date of Birth ..... Social Security # .....

Relationship: ☐ Parent ☐ Guardian ☐ Other

I certify that this information is accurate and that I am responsible for notifying the therapist of any changes in legal guardianship during the course of treatment.

.....
Signature Date

SECTION 4: PERSON TO CONTACT IN CASE OF EMERGENCY

Name ..... Relationship .....

Address .....
(Number/Street) (City/State) (Zip)

Telephone ....
(Home) (Work)

SECTION 5: SECONDARY INSURANCE PLAN - Complete if client is covered by a second policy.

Other Insured's Name .....
(Last) (First) (Middle Initial)

Other Insured's
Policy Group or FECA # ..... Other Insured's Employer/School .....

Insurance Plan/
Other Insured's Date of Birth ..... Sex ..... Program Name .....

SECTION 6: AUTHORIZATION – INSURANCE REQUIRES CLIENT'S SIGNATURE ON BOTH LINES

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

▶ **SIGNED** ..... **DATE** .....

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the therapist for services rendered.

▶ **SIGNED** ..... **DATE** .....

INTEGRATED THERAPY ASSOCIATES
Healing Mind Body Heart

Amanda D'Angelo, Ph.D.

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT
NORTH CAROLINA

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is available in the binder in the waiting area, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

ABOUT INTEGRATED THERAPY ASSOCIATES

I work with a group of independent health and wellness professionals under the name Integrated Therapy Associates. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While the members share a name and office space, I am completely independent in providing you with clinical services and am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

PSYCHOLOGICAL SERVICES

Our first few sessions will involve an evaluation of your needs. I typically conduct an intake assessment that lasts from 1 to 2 sessions. Therapy involves a large commitment of time, money, and energy. Therefore, I approach the intake sessions as a time for us to decide if I am the best person to provide the services you need in order to meet your treatment goals. After the intake is complete, I will typically schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on.

CANCELATION

Once an appointment hour is scheduled, **you will be expected to pay for the full session unless you provide 24 hours advance notice of cancellation** [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that **insurance companies do not provide reimbursement for cancelled sessions**.

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PROFESSIONAL FEES

Service	Fee
Intake Session	$160.00
Individual Psychotherapy (60 minutes)	$150.00
Individual Psychotherapy (45 minutes)	$120.00
Late Cancelation/No-Show	$80.00
Case management*	$150.00/hr. pro-rated per 15 minutes

*Case management services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

TELEPHONE CALLS AND ELECTRONIC MAIL

You are welcome to leave voice messages for me at any time at (910) 799-6162 ext. 04; you may also leave email messages for me at any time at arhdphd@gmail.com. I will make every effort to return your call/email on the same day you make it, with the exception of weekends and holidays. Electronic messages and telephone calls are not meant to take the place of an office visit. I attempt to ensure the confidentiality of your messages, however, there is the possibility that communications can be intercepted and for this reason, please carefully consider the information you include in your messages. My voicemail and email accounts are NOT intended for use during emergencies. If you are unable to reach me and feel that you cannot wait for me to return your call/email, contact your family physician or the nearest emergency room and ask for the psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.

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- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling, billing and quality assurance. All staff members 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.

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- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If I believe that a client presents an imminent danger to his/her health or safety, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you, such information is protected by the psychologist-client privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

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

- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

- If a client files a worker's compensation claim, and my services are being compensated through workers compensation benefits, I must, upon appropriate request, provide a copy of the client's record to the patient's employer or the North Carolina Industrial Commission.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have cause to suspect that a child under 18 is abused or neglected, or if I have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that I file a report with the County Director of Social Services. Once such a report is filed, I may be required to provide additional information.

- If I believe that a client presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

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

While this written summary of exceptions to confidentiality should prove helpful in informing 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 I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

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PROFESSIONAL RECORDS
The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $0.10 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review, which I 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 I 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 my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. A 28% interest rate will be charged in order to compensate for collection fees. If your account has checks returned you will be responsible for all fees incurred.

INSURANCE REIMBURSEMENT
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the

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information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE BEEN OFFERED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Signature_____ Date_____

Print Name_____

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INTEGRATED THERAPY ASSOCIATES
Healing Mind Body Heart

Amanda D'Angelo, Ph.D.

Supplemental Intake Form

Please complete the following as honestly as possible. If an item does not apply, you may leave it blank.

General Information:

Preferred name: _____ Age: _____

Email: _____

Sometimes email communication can be more convenient than speaking over the phone; however, email communication is not as secure as other forms of communication. Do you give permission for Dr. D'Angelo to email you if the need arises?

□ Yes, I give permission to email
□ No, I do not give permission to email

How were you referred to Dr. D'Angelo? _____

Relationship Status:

□ Single □ Married
□ Partnered □ Separated
□ Divorced □ Widowed

Sex/Gender identity: _____

Racial and/or ethnic identity: _____

Sexual orientation: _____

Religious/spiritual identity: _____

Living situation. Type of residence and with whom do you live?: _____

_____

Education and Work Information:

Highest level of education completed:

- □ Grade _____
- □ GED
- □ High school
- □ Some college
- □ Associate's degree
- □ Bachelor's degree
- □ Grad/Prof. degree

Current job status:

- □ Full-time
- □ Part-time
- □ Unemployed
- □ Retired
- □ At-home parent/spouse
- □ Part-time Student
- □ Full-time Student

Job title: _____ Work hrs./week: _____

Employer (for students, name of school): _____

Medical Information:

Name of your Primary Care doctor:

_____

Practicing at what
agency/hospital: _____

Do you see a psychiatrist? □ Yes □ No
Name of psychiatrist:

_____

Practicing at what
agency/hospital: _____

Presenting Concerns:

What is your main reason for coming in today?

_____

_____

_____

Please place a check beside any of the following that apply to you:

☐ depression	☐ anxiety	☐ social discomfort	☐ frequent crying
☐ drug use	☐ alcohol use	☐ anger	☐ frequent arguments
☐ eating concerns	☐ difficulty sleeping	☐ relationship problems	☐ perfectionism
☐ self esteem	☐ suicidal thoughts	☐ family concerns	☐ panic attacks
☐ stress	☐ worry	☐ obsessions/compulsions	☐ disturbing thoughts
☐ childhood abuse	☐ physical assault	☐ sexual assault	☐ sexual concerns
☐ loneliness	☐ sadness	☐ cigarette smoking	☐ sexual orientation
☐ discrimination	☐ harassment	☐ gambling	☐ overeating
☐ racial concerns	☐ weight concerns	☐ dieting	☐ spiritual concerns
☐ assertiveness	☐ self injury (cutting)	☐ problems communicating	☐ parenting concerns
☐ career concerns	☐ financial problems	☐ academic difficulties	☐ legal problems
☐ phobias	☐ social isolation	☐ loss/grief	☐ low energy
☐ restlessness	☐ body image	☐ difficulty concentrating	☐ ADHD
☐ mood swings	☐ chronic pain	☐ post-traumatic stress	☐ delusions/hallucinations

Have you ever been involved in any form of mental health treatment in the past? If so, please describe:

_____

_____

_____

Is there any history of mental health issues in your family? If so, please describe:

_____

_____

_____

Please list medications and medical conditions:

_____

_____

_____

Please describe your use of alcohol and/or drugs:

_____

_____

_____