HERITAGE
Counseling and Wellness
PLLC

www.heritagecw.com
910.240.4599

# Client Information Form

*Please note that this information is confidential.*
*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*

Name of person completing this form: _____

Relationship to the Client: _____

Today's date: _____/_____/_____

***A. Identification***
Full Name of Client: _____
Date of birth: _____/_____/_____
Age: _____
Gender: _____
Name you wish to be called: _____

Address: _____
City: _____ State: _____ Zip: _____

Email address: _____
May we use this e-mail address for communication with you? Yes No

Mobile phone: _____
May we leave a voice message? Yes No
May we send a text message? Yes No

Other phone: _____
May we leave a message? Yes No

Marital Status: (please circle): Single Married Separated Divorced Widowed
Other: _____

Employment Status (please circle): Employed Unemployed Retired Full-time Student Active Duty Military Reserves
Other:_____

***B. Referral***

How did you hear about our practice? Primary Care Provider Friend/Family Website
Other: _____

***C. Your Education and Training***

How many years of school have you had? High School AA/AS BA/BS Master's PhD/MD
Degrees/certificates:_____

Occupation: _____
Have you served in the military? Yes No

***D. Billing and Insurance***

Person Responsible for Billing: _____

Is the client covered under this insurance policy? Yes No

Is Heritage Counseling and Wellness, PLLC In-Network with this Insurance?
Yes No

Insurance company: _____
Phone:_____
Policy #: _____
Group #:_____
Name of insured (if other than yourself):_____
Address of insured (if other than yourself): _____

Is your Insurance Coverage funded fully or in part by the state of North Carolina?
Yes No

Relationship to client (circle one): Spouse Mother Father Step-Parent Guardian

Insured's date of birth: _____
Deductible: _____
Deductible met? Yes No
Co-pay: _____

***E. Emergency Contact (required):***

_____ Check if emergency contact is the same as "Person Responsible for Billing", otherwise please complete below:

Name: _____
Relationship to client: _____
Phones: Mobile (_____) _____ _____ Home (_____) _____ _____
Work (_____) _____ _____

***F. Medical Information***

Primary Care Provider (PCP): _____
Phone (_____) _____ _____ Fax (_____) _____ _____

Do you have any conditions and/or limitations being treated by a medical professional or psychiatrist? Yes No
If yes, please provide physician name:
_____
_____
_____

Please list all current medications:
_____
_____
_____

Previous hospitalizations (date/reason):
_____
_____

Chemical Use:
Do you smoke or chew tobacco? No Smoke Chew
# of packs per week : _____

Do you use vapor or e-cigarettes? No Yes
If yes, how often per week? _____
Do you drink alcohol? No Yes
How many drinks of beer, wine, or hard liquor do you consume in a typical week?
_____

Do you use any other substances? No Yes

Would you like me to contact any of your other health or mental health providers?
Yes* No *If yes, please fill out a Release of Information Form for each provider.

***G. Mental Health and Social History***

Household Members (other than self):
Name: _____ Age: _____
Relationship: _____

Name: _____ Age: _____
Relationship: _____

Name: _____ Age: _____
Relationship: _____

Name: _____ Age: _____
Relationship: _____

Are any members of your immediate family deceased? Yes No

Have you attended therapy previously, or are currently in treatment? Yes No
If yes, Name of Clinician Year and Length of Treatment
_____

Have you ever been diagnosed with a mental health condition? Yes No
If yes, what was the diagnosis? _____

Do you or does any family member suffer from alcoholism, addiction or mental disorders? Yes No
If yes, please explain:

_____
_____
_____

Have you/client ever experienced or witnessed a traumatic event(s)? Yes No
If yes, please explain:

_____
_____
_____

***H. Current Problems or Difficulties***

1. Please describe the main issues that led to your coming to seek therapy?:

_____
_____
_____
_____
_____

2. What are your goals for therapy?

_____
_____
_____
_____
_____

3. Do you have any particular concerns or fears regarding therapy?

_____
_____
_____
_____
_____

Please select all areas of concern for yourself/client:

_____Alcohol or Drug Use Alcohol or Drug use in family _____ Anger/Irritability
_____ Anxiety _____Childhood Abuse or Neglect _____Couples' concerns
_____Depression _____Difficulty Making Decisions _____ Divorce/Remarriage
_____Domestic Violence _____Eating Problems _____Excessive Worry
_____Finances _____Gambling _____Feelings of Guilt _____Grief/Loss
_____Hopelessness _____Hyperactivity _____Impaired Memory
_____Isolation/Withdrawl _____Job Issues _____Less Interest or Pleasure in Things
_____Major Life Change _____Mood Changes _____Muscle Tension
_____Menopause _____Nightmares/Night-terrors _____Obsessive Behaviors
_____ Pain _____Panic _____Parent/Child Conflict _____Poor Concentration
_____Stress _____Sexual Problems _____Self Esteem _____Sexual Assault/Rape
_____School Failure _____Sleeping Problems _____Thoughts of Suicide/Death
_____Thoughts of Homicide _____Weight Loss/Gain _____Cutting or other self-harm

Other:
_____
_____

***H. Other Information***

1. Would you list some of your strengths or accomplishments that are important to you?

_____
_____
_____

2. Would you list some of the coping skills that you currently use to manage stress?

_____
_____
_____

3. Are you/client currently involved in any litigation? Yes No
If yes, please explain: _____

4. Do you feel that you have social/family support? Yes No

Thank you for taking the time to complete this form. When we meet, please feel free to ask any questions about this form, or to tell me anything else that you would like me to know.

By signing, I agree the above information is true, to the best of my knowledge.

_____
CLIENT/GUARDIAN'S SIGNATURE DATE

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# HIPAA Authorization Form

Please complete this form to indicate your preference for how you would like your Protected Health Information (PHI) to be shared.

Client's Name: _____

DOB: _____

**Please select one of the following options:**

_____ Check here if you only want your Protected Health Information (PHI) to be shared with the parties listed in the Notice of Privacy Practices Form.

_____ Check here if you want your Protected Health Information (PHI) to be shared with the parties listed in the Notice of Privacy Practices Form and additional persons indicated below.

| Name | DOB | Relationship to Client |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

_____ _____

Signature of Client (or Client's Guardian or Agent) Date

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# Notice of Privacy Practices

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This form is effective May 2026.

Heritage Counseling and Wellness, PLLC, only releases information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes our company policies related to the use and disclosure of a client's Protected Health Information (PHI).

## Confidentiality

As a rule, Heritage Counseling and Wellness, PLLC will disclose no information about you, or the fact that you are a patient at our practice, without your written consent. You can revoke your prior consent to share your Protected Health Information (PHI) at any time by notifying your therapist in writing. Your formal mental health records describe the services provided to you and contain the dates of your sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports.

## Limits of Confidentiality

Your therapist may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required**:**

**Treatment, Payment, and Health Care Operations:** Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your PHI for these purposes:

**For Treatment**.
Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment**.
Your PHI may be used and disclosed so that we can conduct payment activities for the treatment services provided to you. Examples of payment-related activities are: making a

determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity / coverage / justification of charges, undertaking audit activities, conducting risk adjustments, and utilization review activities . If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations**. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For more information regarding HIPAA compliant uses and disclosures for treatment, payment, and health care operations, please visit: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html

**Required by Law**. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

North Carolina law requires all services funded by state dollars to be reported to the state health information exchange (HIE), also known as NC HealthConnex. Beginning 01/01/2022, Heritage Counseling and Wellness PLLC will begin submitting data to the HIE in an effort to meet the data standards that comply with the NC HealthConnex Privacy and Security Policy and the Behavioral Health Sensitive Data Policy. Required data which will be transmitted include patient and provider demographics, encounter information such as the date and time of the session, service codes, and the patient's diagnosis code. Patient diagnosis codes are marked as confidential. This is done to hide the patient's diagnosis code from any other user of the HIE unless the user affirmatively indicates a need-to-know of the diagnosis. Substance abuse records or psychotherapy notes will not be submitted. While the law does allow a patient to opt-out of data sharing from HealthConnex, the law still requires providers to submit the patient data to HealthConnex.

The N.C. General Assembly has created a way for patients to prevent information submitted to NC HealthConnex from being shared between participating health care providers, called "Opt Out." For more information please refer to: https://hiea.nc.gov/patients/your-choices

For More information about the NC Health Connex please refer to: https://hiea.nc.gov/patients

NC HealthConnex Privacy and Security Policy: https://hiea.nc.gov/privacy-security-policy

Behavioral Health Sensitive Data Policy:
https://hiea.nc.gov/behavioral-health-sensitive-data-policy

**Family or Group Therapy**: While confidentiality is encouraged by your therapist in group or family therapy, the therapist can not ensure that other participants will maintain your confidentiality.

**Medical Emergency**: We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency. If a therapist believes that a client presents an imminent danger to the health and safety of him/herself or another person, the therapist 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, the therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

**Child Abuse Reporting**: If your therapist has reason to suspect that a child is abused or neglected, he/she is required by North Carolina law to report the matter immediately to the North Carolina Department of Social Services.

**Adult Abuse Reporting**: If your therapist has reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, he/she is required by North Carolina law to immediately make a report and provide relevant information to the North Carolina Department of Welfare or Social Services.

**Health Oversight**: If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Court Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and your therapist will not release information unless you provide written authorization or a judge issues a court order. If your therapist receives a subpoena for records or testimony, he/she will notify you so you can file a motion to quash (block) the subpoena if you desire.

Professional time spent responding to legal matters will be a pro-rated fee of $182 per hour.

Emails and other forms of contact are also a part of the client record, therefore discoverable by parties holding legal right to these records.

**Deceased Patients**: We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in their care or payment for care prior to death, based on prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Family Involvement in Care**: We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Law Enforcement**: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions** :It is our policy to permit the use and disclosure of PHI for specialized government functions including military and veterans' activities, national security and intelligence activity, protected services for the President and others, medical suitability determinations, correctional institutions and other law enforcement custodial situations, and government programs providing public benefits.

**Public Health**: If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety**: We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research**: PHI may only be disclosed after a special approval process or with your authorization for the purpose of research.

**Fundraising/Marketing**: We may send you fundraising/marketing communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

**Verbal Permission:**. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

*Other uses and disclosures of information not covered by this notice or by the laws that apply to the practice of counseling will be made only with your written permission.*

## Client Rights and Provider Duties

**Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information your therapist discloses about you to someone who is involved in your care or the payment for your care. If you ask your therapist to disclose information to another party, you may request that he/she limit the information they disclose. However, your therapist is not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and notify your therapist of: 1) what information you want to limit; 2) whether you want to limit the therapist's use, disclosure or both; and 3) to whom you want the limits to apply.

**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 a therapist. Upon your request, your therapist will send your bills to another address. You may also request that your therapist contact you only at work, or that he/she do not leave voicemail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

**Right to an Accounting of Disclosures:** 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 the Limits to Confidentiality section of this Notice). On your written request, I will discuss with you the details of the accounting process

**Right to Inspect and Copy:** In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, a fee will be charged for costs of copying and mailing. Your request to inspect and copy your PHI may be denied in some circumstances, if your therapist believes that access would likely cause harm to the client or others. You may not be granted access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

**Right to Amend:** If you feel that protected health information your therapist has about you is incorrect or incomplete, you may ask your therapist to amend the information. To request an amendment, your request must be made in writing, and submitted to your therapist. In addition, you must provide a reason that supports your request. Your therapist may deny your request if you ask him/her to amend information that: 1) was not created by him/her; your therapist will add your request to the information record; 2) is not part of the medical information kept by your therapist; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

**Breach Notification:** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

**Right to a copy of this notice:** You have the right to a paper copy of this notice. You may ask your therapist to give you a copy of this notice at any time.

Changes to this notice: Therapists reserve the right to change their policies and/or to change this notice, and to make the changed notice effective for medical information your therapist already has about you as well as any information he/she receives in the future. The notice will contain the effective date . A new copy will be given to you or posted in the waiting room. Your therapist will have copies of the current notice available on request.

## Complaints

If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to our office. You may also send a written complaint to the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. Heritage Counseling and Wellness, PLLC will not retaliate against you for filing a complaint.

The effective date of this notice is May 2026.

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# Client's Acknowledgement of Receipt of Notice of Privacy Practices

Client Name: _____

DOB: _____

I hereby acknowledge that I have been provided a copy of Notice of Privacy Practices for Heritage Counseling and Wellness, PLLC. My therapist and I have discussed these policies, and I consent to accept these policies as a condition of receiving mental health services.

I understand that if I have any questions regarding this notice or my privacy rights, I can contact Victoria Butler at victoriabutler@heritagecw.com or 910.984.5030.

_____

Signature of Client Date

_____

Signature of Parent, Guardian, or Personal Representative Date

_____

Relationship/Authority to act for the client (parent, power of attorney, etc): Date

_____

Signature of Staff Member Date

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# Informed Consent for Services and Policies

Welcome to Heritage Counseling and Wellness, PLLC. We are honored that you chose to begin therapy with us. *Thank you.*
The following information will help you to understand our professional services and business policies.

## Psychotherapy Services

Psychotherapy is a collaborative process through which the client works with a therapist to identify and resolve particular issues in their lives. This process is successful as a trusting relationship is formed between the therapist and client, sessions occur on a regular basis, and new skills are practiced between sessions.

The first one to three (1-3) therapy sessions are called intake sessions. Here, you and your therapist will discuss your background information, your current concerns, your diagnosis (as this is required by insurances), and your goals for therapy. After your intake session(s), you and your therapist will work together to create a treatment plan based on your goals and diagnosis. From there, you and your therapist will work together to achieve your therapeutic goals. If you feel that you are not making progress toward your goals, your therapist will be happy to assist you in getting a second opinion and/or transferring your care to another provider.

There are potential benefits and risks of therapy. The greek word for therapy means “change”, and change requires an adjustment period for individuals and their relationships.
Since therapy often involves dealing with difficult aspects of a client’s life, they may experience uncomfortable feelings during treatment. It is important that you discuss ways to maintain emotional and physical safety between sessions. Limits to therapy may include: infrequent sessions, lack of trust and rapport in the therapeutic relationship, and/or failure to practice skills outside of sessions.

Therapy also has many benefits including: education about mental health, personal and relational growth, problem-solving strategies, improvement in distressing symptoms, and development of healthy coping skills.
If you ever have questions about your treatment, please discuss these with your therapist.

For Minor Clients:
*We request that the child's custodial parents or guardian attend the first session (without the child present) to discuss background information and concerns*.
For the following sessions, the child is invited to attend sessions (with parents or individually, based on the child's comfort level). We will work together to identify goals for treatment, and create a treatment plan to reflect these goals. Parents will be asked to attend parent sessions throughout the child's treatment in order to assess progress, and parents will also be encouraged to attend some sessions with the child in effort to build/practice new skills.

## Appointments, Cancellations, and Fees

Sessions usually occur once per week, or every other week. Sessions become less frequent as treatment progresses and issues are improving. It is vital for your therapeutic progress that you attend your sessions, therefore, it is strongly encouraged that you keep appointments unless absolutely necessary to cancel or reschedule.

If you do need to cancel or reschedule, please do so within 24 hours of your appointment time, as a fee of $75 will be charged to clients who do not give 24 hour notification for missed appointments.

## Termination of Treatment

Your therapy is voluntary, and may be ended at any time. If you feel that you are ready to end your treatment, please let your therapist know and schedule a termination session, which is a time for you and your therapist to review your progress and have closure to the counseling relationship.
If you are not keeping your appointments and have more than three no-shows or late cancellations (less than 24 hour notice) within a six-month period, you may be discharged from treatment.

## Contacting Your Therapist

Due to work schedules, your therapist may not often be immediately available by telephone. When your therapist is unavailable, his/her telephone will be answered by voicemail. Your therapist will make every effort to return your call within 24 hours, with the exception of weekends and holidays.
Additionally, you may e-mail your therapist at their direct e-mail or at info@heritagecw.com to discuss scheduling or other nonclinical matters.
*If you are having a mental health emergency, and/or are at risk of harming yourself or others, call 911, go to the nearest hospital and ask to speak with the psychiatrist on call, or call Holly Hill Hospital's Response line at 919-250-7000.*

In the event that your therapist can not continue to provide services due to incapacitation or death, please consider contacting one of the following agencies for recommendations regarding continued care: your local health department, your primary care physician or psychiatrist, or Holly Hill Hospital.

## Role of Technology and Limitations

If you provide consent for us to e-mail, call, or text you, we will use these means to communicate with you for the purposes of: scheduling, providing resources, brief check-ins, and/or providing skills to practice between sessions. Any other communication via electronic communication is discouraged so as to help maintain the confidentiality of therapy. If you are using an unsecure means of communication (like text message, google, Yahoo, aol, etc.), you are acknowledging that this is an unsecure means of communication and you will not hold Heritage Counseling and Wellness, PLLC liable if the information shared is breached.
**DO NOT email or text if you have an emergency (rather refer to the contacts listed above).

## Confidentiality

The law protects the privacy of all communications between a client and a therapist. In most situations, your treatment information will only be released to others if you sign a written authorization form that meets HIPAA requirements. However, there are a few exceptions. In certain situations when the client is a danger to self and/or others or in circumstances of suspected child, adult, or elder abuse or neglect, the therapist is required by law to report this to the appropriate protective agency without consent. We may also share your protected health information for the purposes of treatment, payment, and health care operations (TPO).

*Consultation with other professionals*: At times, therapists will consult with other professionals regarding cases. During these consultations, all efforts will be made to de-identify information so that the other professionals will not be able to identify the client. These professionals are licensed in their respective disciplines and bound by the same confidentiality rules.

North Carolina has passed a law that requires all services funded by state dollars to be reported to the state health information exchange (HIE), also known as NC HealthConnex. Beginning 01/01/2022, Heritage Counseling and Wellness PLLC will begin submitting data to the HIE in an effort to meet the data standards that comply with the NC HealthConnex Privacy and Security Policy and the Behavioral Health Sensitive Data Policy. Required data which will be transmitted include patient and provider demographics, encounter information such as the date and time of the session, service codes, and the patient's diagnosis code. Patient diagnosis codes are marked as confidential. This is done to hide the patient's diagnosis code from any other user of the HIE unless the user affirmatively indicates a need-to-know of the diagnosis. Substance abuse records or psychotherapy notes will not be submitted. While the law does allow a patient to opt-out of data sharing from HealthConnex, the law still requires providers to submit the patient data to HealthConnex. The N.C. General Assembly has created a way for patients to prevent information submitted to NC HealthConnex from being shared between participating health care providers, called "Opt Out." For more information please refer to the following: https://hiea.nc.gov/patients/your-choices. For More information about the NC Health Connex please refer to the following: https://hiea.nc.gov/patients.

(**Please see "Notice of Privacy Practices" form for more specific information about confidentiality, your rights, and access to your records.)

### Use of Diagnosis and Intended Uses of Tests and Reports

A mental health diagnosis is required when a client is submitting claims for insurance benefits. It is also important to use and understand diagnoses in effort to build an effective treatment plan, as goals will address symptoms of the presenting diagnoses.

If your therapist uses any assessments or screening tools, the purpose and goals of using such tools will be discussed with you. Additionally, reports written or received on your behalf will also be discussed during the course of your treatment.

## Professional Records

The laws and standards of the mental health profession require that therapists keep Protected Health Information (PHI and e-PHI) about clients in a clinical record. These records are securely kept and maintained in an Electronic Health Records system. In these records, your therapist will document brief therapy notes, time and date of sessions, content discussed in session, and your progress toward goals and any homework. Except in unusual circumstances, whereby disclosure would cause endangerment to the physical safety of the client or someone else, clients have the right to request a copy of your records, or a summary of records. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them with your therapist so that we can discuss the contents.

Clients will be charged a pro-rated fee of $182 per hour for any professional time spent in responding to information requests.

## Limits to Litigation

If you become involved in a custodial or divorce lawsuit, please acknowledge by signing this form, you understand that therapists at Heritage Counseling and Wellness, PLLC are not trained to make custodial recommendations. A therapist's involvement in such cases is a potential risk to the therapeutic relationship. We feel that it is best practice for therapists not to become involved with legal proceedings. Requesting your therapist's involvement or disclosure of records for the purpose of a lawsuit may be grounds for treatment termination.

Any professional time spent, including record preparation, responding to requests from parents, attorneys, or court officials will be charged a pro-rated fee of $182 per hour.

## Minors and Parents

In the state of North Carolina, children less than 18 years of age cannot independently consent to or receive mental health treatment without parental consent. While privacy in psychotherapy is very important, particularly with adolescents, parental involvement is also essential to successful treatment, and this may require that some private information be shared with parents or guardians.

It is our policy that we not provide treatment to a child under 18 unless he/she agrees that his/her therapist can share general information about the progress of the child's treatment with the parents or guardian. Before giving parents information, your therapist will discuss the matter with the child, and, if possible, do his/her best to handle any objections the client may have, unless the therapist feels that the child is in danger or a danger to someone else. In this case, the therapist will notify the parents or other authorities of the concern immediately, regardless of any objections the child may have.

It is recommended that both parents be included on all emails regarding the treatment of a minor child.

Be advised that emails and communications with parents are included in the minor's record, and are therefore discoverable by all parties holding custody.

### *Consent for Minors*

In order to provide the necessary consent for treatment of your child, you must have sole legal custody or shared legal custody or legal guardianship.

Our services are considered "health appointments", so if you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, it is your legal duty to do so.

**A copy of your custodial agreement will be requested for us to maintain in the child's file.*

## Interns/Supervisees

As part of our on-going commitment to the field, Heritage Counseling and Wellness, PLLC, sometimes participates in the training and supervision of Masters-level therapists. As you consent, one training therapist may join your licensed therapist during a session. All staff/trainees at our practice are bound under the same confidentiality guidelines. By request, you will be provided with the intern's school, degree and experience.

## Insurance Information

Many of the services we provide are covered by health insurance plans. Benefits vary from plan to plan, and insurance contracts do not always provide coverage for all services. Therefore, it is important for you to review your policy carefully.

1. It is your responsibility to know your insurance coverage including: your eligibility, benefits, co-pays, telehealth benefits, and reimbursement policies.
2. Your insurance company will require your therapist to include the following information on billing statements: Procedural Code (CPT code) and a Primary Diagnostic Code (ICD code). Insurance companies will require a diagnosis to be given in order to cover your claim. Your therapist can discuss these with you upon your request.
3. By submitting your insurance information to Heritage Counseling and Wellness, PLLC and requesting that we bill on your behalf, you are giving us the following:
    - Permission to share your private health information (PHI) with our contracted billing agency and with your insurance company to process the insurance claims, audits, risk adjustments, and billing activities on your behalf.
    - Permission for your insurance company to reimburse this provider directly.

## Financial Information and Billing Practices Form

### Fee Schedule

The following fee schedule outlines the services available and the current fees associated with those services. Please note that these fees are reviewed periodically and subject to revision.

**Services**

| | |
|---|---|
| Intake | $240 |
| Individual or family therapy 53-60 min. | $182 |
| Individual or family therapy 38-52 min. | $130 |
| Individual or family therapy 16-37 min. | $100 |
| Parent Session (without child present) | $110 |

*Other professional time conducted by your therapist (e.g. telephone consultations, letter writing, etc.) is prorated and based on an hourly rate of $182.

- If you are using health insurance for mental health benefits, your co-pay amount and any outstanding balances will be due at the beginning of each session.
- If a client's account has a balance for 90 days or more, Heritage Counseling and Wellness, PLLC may send it to collections, which could result in additional fees. If a client is unable to pay for services, we will assist the client with referrals to alternative services.
- If a therapist is called for court (either physical presence or phone stand-by), a fee of $300 dollars per hour will be due. This rate will be charged for all activities related to preparation for, travel to and from, and participation in litigation. A minimum of $300 will be assessed prior to the count date in order to cover the therapist's preparatory time. *These fees are higher due to the difficulty of participating in legal matters.*

- We accept cash, checks, debit cards, VISA, Mastercard, Discover, American Express, and HSA/FHA cards for the payment of insurance co-payments and/or session fees.

## Information About Medical Insurance

**In Network and Out of Network Insurances**

We are happy to file claims to your health insurance company for the services that you receive at our office. In order for the claims to process, please ensure that the information you provide in your client information form is correct.

By signing this form, you authorize the office to provide necessary protected health information that is required to process your claim.

If you have changes in your insurance information, please let us know immediately.

- If you wish to file with a secondary insurance, it is your responsibility to inform us that you would like this service done.
- Co-payments, coinsurance and deductibles are due at the time of service.
- A copy of your insurance card is required prior to your first appointment. Failure to provide this could result in your claim being denied, and you will be responsible for the full payment.
- We are contracted with several insurance providers, but this does not guarantee that your particular insurance plan will cover the services we provide to you. Please remember that you are responsible for timely payment of all charges that are not covered by your insurance.

**CREDIT CARD AUTHORIZATION**

Through our practice management software, TherapyNotes, we are able to store credit card data. Credit card data is encrypted, helping to protect private payment information from tampering. This allows Heritage Counseling and Wellness, PLLC to maintain your credit card information for the purpose of payments for: co-pays, fees, services not covered by insurance, etc.

Please designate your preference below:

_____ I DO wish for my credit card to be stored on file.

_____ I DO NOT wish for my credit card to be stored on file.

## Commitment to Quality Treatment/Client Rights

At Heritage Counseling and Wellness, PLLC, we are committed to providing quality services. At any time, you have the right to ask questions about your treatment.

**Your signature below indicates that you have read the information in this document and you voluntarily consent to receive therapy services at Heritage Counseling and Wellness, PLLC, and you agree to abide by the terms and policies listed above. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. Actions taken prior to the revocation of the consent are not subject to revocation. **If signing for a minor, my signature affirms that I have legal right to consent for services for this child.**

_____

**Client Name**

_____

**Your Name (Print if authorizing treatment for a minor)**

_____

**Relation to Client (if authorizing treatment for minor)**

_____

**Signature** **Date**

_____

**Signature of Staff Member** **Date**

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# Telehealth Consent For Services

Telehealth has the same purpose or intention as psychotherapy treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that telehealth may be experienced somewhat differently than face-to-face treatment sessions.
I understand that I have the following rights with respect to telehealth:

1. I understand that at times telehealth may be a form of treatment my therapist and I may discuss to continue my treatment when I cannot physically be present in my therapist's office. Examples of appropriate times to use telehealth include, but are not limited to: Safety protocol of COVID-19, recovering from an illness and not being able to travel, lack of access to transportation to the office, return to college, unsafe weather conditions, etc.

2. I understand that telehealth is an option in which my therapist and I may use the internet on various devices, computer, tablet, phone, and will be able to see and hear each other and interact in real time to engage in psychotherapy.

3. I understand that the policy at Heritage Counseling and Wellness, PLLC is to use private platforms like Zoom and Webex whenever possible. I understand that these platforms strive to comply with HIPAA standards. However, the agencies which certify health technology for HIPAA compliance do not currently provide accreditation to non ERA platforms such as these. I understand that the use of these platforms are less secure as compared to an in-office therapy session and increase the risk of private healthcare information being breached.

4. I understand that when I am engaged in telehealth psychotherapy, it is my responsibility to choose a secure location to ensure that family, friends, employers, co-workers, strangers, or hackers cannot overhear my communications or have access to the technology or devices I am using.

5. I understand that, on my end, it is my responsibility to make sure that I am using a private and encrypted WiFi, (never a public WiFi) and that my devices have protections like firewalls, anti-virus software and are password protected. I understand that my therapist is using the same standards on their devices to protect my privacy and confidentiality.

6. I understand that my therapist may only use telehealth in states where they are licensed. For example, I understand that only clinicians licensed to practice in North Carolina, per the law,

may practice therapy in North Carolina. This means that the client must also be present in the state in which the therapist is licensed.

7. I understand that most insurances now cover some form of telehealth and that my therapist will have my benefits checked as a courtesy, but it is, ultimately, my responsibility to know whether or not my insurance company covers telehealth sessions.

8. I understand there may be risks to telehealth psychotherapy, including but not limited to: poor internet connections, technical difficulties, power failures in the middle of a session, etc.

9. I understand that if there is a loss of transmission, my therapist will call me on the phone to complete the session. Sometimes phone sessions are not covered by insurance--there may be a private fee assessed for any part of a session that has to be completed via phone.

10. I understand that I can discontinue telehealth psychotherapy sessions and revoke this authorization at any time without affecting my right to future care or treatment. I also understand that my therapist has the right to discontinue telehealth sessions at any time if it becomes apparent that face-to-face treatment with the therapist would be more appropriate.

11. I understand that I may benefit from telehealth psychotherapy sessions, but that results cannot be guaranteed nor assured.

12. I accept that telehealth is not an emergency service. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24-hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for telehealth services. If this is the case or becomes the case in future, my clinician will recommend more appropriate services.

13. I understand that dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

14. I understand that this informed consent for telehealth psychotherapy is only in addition to my informed Consent for Services and does not replace it.

Emergency Protocols:
Your therapist needs to know your location in case of an emergency. (Please initial below).

_____ I agree to inform my therapist of the address where I am located at the beginning of each session.

My therapist also needs a contact person who they may contact on my behalf in a life-threatening emergency. This person will only be contacted to go to my location or take me to the hospital in the event of an emergency.

_____
Emergency contact name

_____
Relationship

_____
Street address

_____
City/state/zip

_____
Phone

By signing this form, I certify:
a. That I have read or have had this form read and/or had this form explained to me.
b. That I fully understand the risks and benefits of telehealth psychotherapy.
c. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____
Name (printed):

_____
Client signature:

_____
Date

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# Outdoor Counseling Informed Consent

I, _____, agree to outdoor counseling, a therapy session that takes place outside of my counselor's office at Heritage Counseling and Wellness PLLC. This form serves as a supplement to the general informed consent I signed when initiating services.

I am aware that outdoor counseling may take several forms. It may involve sitting on a bench outside of the office or sitting in a public place. It may also take the form of walking/moving while addressing therapeutic goals and topics.

**By signing this form, I agree to the following**:

1. I understand that participation in outdoor therapy is completely voluntary and that there are alternative options such as teletherapy or in-office services available.

2. I agree that I am responsible for selecting the location and/or setting the physical pace of the outdoor session.

3. I understand that this is not exercise or athletic/personal training, and that while movement may benefit me physically, the focus will remain therapeutic in nature.

4. I agree to communicate with my counselor if I am uncomfortable physically or emotionally while participating in outdoor counseling. In such a case, the outdoor session would discontinue and would instead continue in the office building.

5. I agree that the counselor has the right to terminate the outdoor therapy session and return to their indoor office at any time based on clinical judgment.

6. I take full responsibility for my medical and physical well-being and will not hold Heritage Counseling and Wellness, PLLC or their landlord legally or financially responsible for any medical conditions and/or accidents that may arise during outdoor therapy.

7. If I have any medical conditions that could arise or be detrimental during outdoor therapy, I agree to obtain approval from my doctor and will disclose information relevant to this condition to my counselor prior to engaging in outdoor counseling.

8. I understand that while my counselor will take reasonable steps to ensure confidentiality and privacy during my outdoor counseling appointment, there is a risk that my session will be less private than an appointment inside the office.

For example:

a. I understand that if the counselor and I encounter a person I know, I have the right to disclose or not to disclose that I am receiving services and/or the relationship with my counselor. I understand that the counselor will defer to my decision, should this situation arise.
b. I understand that if the counselor should encounter a person they know, they will not acknowledge me as a client to preserve confidentiality.
c. I understand that both the counselor and I will be visible to the public, and that being seen may lead to assumptions that I am connected to counseling at Heritage Counseling and Wellness, PLLC. I consent to taking this risk.
d. Given the prevalence of cellphones, it is also possible that I may be photographed or videoed with my therapist without my knowledge and that myself or my therapist would have no control over the dissemination of those photos/videos.

9. Perceived informality of the interaction. Although outdoor therapy might feel more like a social interaction rather than a therapeutic interaction, it is a therapeutic activity. Despite the relative informality of the interaction, the relationship between client and therapist will remain entirely professional and not social in nature.

10. This consent can be withdrawn at any time by submitting a request in writing to your counselor.

11. If I have any questions regarding anything in this document, I will request clarification from my counselor prior to signing.

By signing below, I understand that I am consenting to the above-mentioned conditions and risks regarding Outdoor Therapy.

Signature of Client: _____

Date: _____

Staff Signature: _____

*Outdoor Therapy is an option for this specific counselor and is in no way reflective of the services provided by other counselors at Heritage Counseling and Wellness, PLLC. .