Drayton's View
Therapy and Wellness Services, PLLC
Where Healing Meets Perspective
910-929-2103 | connect@draytonsviewtherapy.com | draytonsviewtherapy.com
130 Pine State Street Suite C, Lillington, NC 27546

Client Acknowledgement (Please initial each section)

Emergencies

If you are in immediate danger, please call 911 or go to the local emergency room.

Initials: _____

HIPAA Privacy Practices Acknowledgment

The U.S. Congress recognized the importance of privacy of medical records when the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted. The privacy regulations establish that personal health information must be kept confidential. The regulations are designed to safeguard the privacy and confidentiality of a consumer's health information, especially in this age of rapid advances in technology and the subsequent ease with which information can be transmitted. The regulations establish a baseline of patient/client protections by defining the rights of individuals, the administrative obligations of covered entities, and the permitted uses and disclosures of protected health information. Protected health information may not be disclosed by a covered entity without the informed and voluntary written consent or authorization of the client (see limits below). A covered entity is required to obtain a client's consent for use or disclosure of client information for purposes of health care treatment, payment, and operations. Disclosure must be limited to the minimum amount necessary for the purposes of disclosure, with the exception of transferring records for treatment, when providers need access to the full record to ensure quality care. A client's authorization is required for any other type of disclosure. Note: Under HIPAA law, Psychotherapy notes are excluded from the provision that gives clients the right to see and copy their health information. Confidentiality and Authorization to Release Information Issues discussed in therapy are important and generally legally protected as both confidential and "privileged." No identifying information will be given to anyone without your written permission (as discussed above). The only exceptions are as follows: -Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.-Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social services and/or legal authorities.-Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. -

Insurance Providers (when applicable): Insurance companies and other third party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of service, diagnosis, treatment plan, and other descriptions of care. COMPLAINTS You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment or office policies, please inform us immediately and discuss the situation.

Initials: _____

Financial Agreement

• Payment is due before services are rendered.

• All fees for services rendered are non-refundable.

• Cancellation Policy: Appointments must be cancelled at least 24 hours in advance or a $75 late cancel/no-show fee will be charged (not billable to insurance).

• Client is responsible for all copays, deductibles, coinsurance, and non-covered services.

• A valid payment method must be on file.

• Returned checks incur a $25 fee.

• Accounts may be sent to collections for nonpayment; client pays applicable collection costs/fees.

• Disputed/chargeback fees resulting from valid charges may incur an additional administrative fee up to $250.

• Collections Policy: We reserve the right to turn any client/responsible party over to a collection agent if it is deemed that the account is in default of payment obligations or for noncompliance with this policy. Should clients account be turned over to a collection agent, client/responsible party is responsible for a $75.00 collection fee or 20% of total, whichever is greater. Clients/responsible party will be required to pay outstanding balances in full before being scheduled in our office again. Clients/responsible parties whom do not comply with this policy may be dismissed from the practice. Only emergency care will be provided for a 30 day grace period following dismissal from the practice.

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Fees and Payment

Non-Customary Fees / Usual and Customary Rates: Our practice is committed to providing the best treatment for our clients and charge what is usual and customary for our area. Client/responsible party is responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. For clients/responsible parties in need of non-customary services, Drayton's View Therapy and Wellness Services, PLLC offers an optional Expedite Fee allowing clients/responsible parties in need of reports to be generated under stringent time constraints the ability to receive the documents, reports, and/or other services within 5 business days at our rate of $100 per request for expedited services in addition to our $150 per hour fee for non-customary services plus $1 per page for records/documents produced and/or digitally delivered. Services such as document preparation for legal proceedings, court testimonials, and other non-customary services are at the discretion of Individual provider. A deposit for such services is required at the time of request. All requests for such services must be submitted to Meaningful Minds Counseling in writing by client/responsible party. Standard time to prepare and deliver requested services is 10 business days.

Copying Fee $10.00 Pages 1-25 $0.75 per page Pages 26-100 $0.50 per page Pages 100 + $0.25 per page An optional Expedite Fee allowing clients/responsible parties in need of reports to be generated under stringent time constraints the ability to receive the documents, reports, and/or other services within 5 business days at our rate of $100 per request for expedited services in addition to our $150 per hour fee for non-customary services plus $1 per page for records/documents produced and/or digitally delivered. Services such as document preparation for legal proceedings , court testimonials, and other non-customary services are at the discretion of Individual provider. A deposit for such services is required at the time of request. All requests for such services must be submitted to Drayton's View Therapy and Wellness Services, PLLC in writing by client/responsible party. Standard time to prepare and deliver requested services is 10 business days.

Regarding Insurance: We may accept assignment of insurance benefits, however, deductibles, co-insurance and co-payments MUST be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We are unable bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company, we will require a preapproved payment plan or a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account with 30 days, patient is responsible for all unpaid balances, becoming patient's

responsibility to collect claim fees from insurance provider. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary.

Initials: _____

Credit/Debit Card Payment Consent

Stored Payment Options: Client agrees to provide payment information (credit/debit card) to account via the client portal or with staff member which is encrypted to clients account to be used in the event of non-payment, co-pays, deductible/cost share, missed appointment fees and/or non-customary fees. Client may add or edit payment information at any time as well as store multiple payments options in account.

Cardholder Name (if different than client): _____

Card Type: _____ Number: _____ Expiration: ____/____ CVV: ____

Card Type: _____ Number: _____ Expiration: ____/____ CVV: ____

Card Type: _____ Number: _____ Expiration: ____/____ CVV: ____

Authorization: I authorize Drayton's View Therapy and Wellness Services, PLLC to charge my credit/debit/health account card for professional services before our scheduled appointment.

If I do not cancel within 24 hours, I understand my card may be charged a late cancel/no-show fee.

I verify that my payment information is accurate. If a payment is declined or fraudulent, I am responsible for all amounts due and any costs incurred.

If unpaid balances remain after 30 days, my account may be turned over to collections.

Client Signature: _____ **Date:** _____

Witness/Staff Signature: _____ **Date:** _____

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Insurance Policy

As a courtesy, Drayton's View Therapy and Wellness Services, PLLC will submit primary insurance claims on behalf of patients. Patients are responsible for payment of designated Co-Pay amount per their policy prior to services at each appointment. It is patient's responsibility to know co-pay amount per their policy. All insurance recipients must present their current insurance card and picture ID at the time of service. Picture identification is utilized for ID purposes only. If you do not have your insurance card, you will be considered a self-pay patient at time of service. If you have insurance that is primary with any other insurance as secondary, you must provide this information at the time of service. Clients with secondary insurance are responsible for balance due from primary insurance and filing claims with secondary. If patient fails to disclose both primary AND secondary insurance, your claim will be denied, and the patient is then immediately responsible for full amount due. We do not file claims for services provided after the services have been rendered. (All services not covered by your insurance company will be due at the time of service. It is your responsibility to know the provisions of your policy.) Please notify this office immediately of any changes in your insurance coverage or change of insurance carriers. If your insurance company has not paid their portion of your claim within 30 days, patient is responsible for all unpaid balances and must recover fees from insurance provider.

Insurance Information

- **Primary Insurance Company:** _____
- **Insurance Phone Number (on back of card):** _____
- **Policy/ID Number:** _____
- **Group Number:** _____
- **Policy Holder's Full Name:** _____
- **Policy Holder's Date of Birth:** ____ / ____ / _____
- **Policy Holder's Address (if different):** _____

Secondary Insurance (if applicable)

- **Secondary Insurance Company:** _____
- **Policy/ID Number:** _____

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- **Group Number:** _____
- **Policy Holder's Full Name:** _____
- **Policy Holder's Date of Birth:** ____ / ____ / _____

Coverage Information (completed by client or office)

- **Type of Plan:** ☐ HMO ☐ PPO ☐ POS ☐ Other: _____
- **Does plan require authorization/referral?** ☐ Yes ☐ No
- **Mental Health Benefits Phone # (from card):** _____
- **Deductible (amount and status):** _____
- **Co-Pay per Session:** _____
- **Co-Insurance %:** _____
- **Number of Sessions Allowed per Year:** _____
- **Effective Date of Policy:** ____ / ____ / _____
- **Out-of-Network Coverage?** ☐ Yes ☐ No

Client Responsibilities

- I understand that I must provide a valid insurance card and photo ID prior to services.
- I understand that I am responsible for any fees not covered by my insurance, including co-pays, deductibles, co-insurance, late cancellations, or no-show fees.
- If I fail to disclose secondary insurance, I am responsible for denied claims and balances owed.

I have read and fully understand this Insurance Policy and agree to abide by all.

Client/Guardian Signature: _____ Date: ____ / ____ / _____
Witness/Staff Signature: _____ Date: ____ / ____ / _____

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Appointments and Cancellation Policy

Standard sessions are approximately 50 minutes.

Cancellations require 24 hours' notice to avoid a $75 late cancel/no-show fee (No show is defined as being 15 minutes or more late to a scheduled appointment or not showing for scheduled appointment).

Insurance does not cover missed appointments.

Repeated no-shows may result in dismissal from care.

Initials: _____

Telehealth Treatment Consent

Telemental health is live two - way audio and video electronic communications that allow therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access.

I understand that any internet-based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment.

I understand credit cards or other forms of payment will be established before the first session. I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.

PHONE CONTACT - If a situation requires telephone consultation that exceeds five minutes, this becomes a telehealth session and will be charged by insurance accordingly. If, with your permission, I contact other people on your behalf—such as teachers, or other health care professionals—and consult with them in person or by telephone a $25 fee per 15 minute segment is applied.

Initials: _____

Minor Client Section

Clients under the age of 18 will only be treated when accompanied by a parent, legal guardian or other adult with legally recognized documentation giving Provider permission for treatment of the

minor from the parent/guardian. Parent or guardian MUST remain on Meaningful Minds Counseling premises during the time the minor child is being seen by Professional. If at any time a parent or guardian is unable to remain on site during the minor client's appointment, parent and/or guardian must notify Provider they have made arrangements to have a responsible adult stay on the premises while the minor child attends his/her appointment. In the event any parent/guardian wishes to consult with Provider without the client present, an adult must accompany family to appointment and remain with minor client while parent/guardian is with Provider.

Initials: _____

Record Keeping & Confidentiality

A clinical record is maintained documenting dates of service, assessments, diagnoses, treatment plans, progress notes, and fees.

Records are released only with written authorization, except when permitted/required by law (e.g., risk of harm, abuse reporting, court orders, or insurer requests for treatment/payment/operations).

Psychotherapy notes may have additional protections.

Initials: _____

Non-Customary Services

SUBPOENA Court Related and/or Child/Adult Specialist Work for Collaborative Law Cases: $300 per clock hour. Preparation of Summaries of Treatment or Letters at request of client: $150 per item requested. Additional Times Spent on Affidavits or other court related paperwork $200.00 per clock hour. Travel expenses from therapy office to place of interest determined by courts - .70 /mile and $25.00 per 30 minutes of travel. Requirement for Therapist to be 'on call' during or for court case: $500/day. Administrative Fee for Record Copy Requests: $100. Retainer Fee: A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 "express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1500).

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Termination Agreement

If there is no contact or communication for 30 days, the case may be closed, and you may return in the future if you wish to resume care.

Services may also be terminated for non-payment of agreed-upon fees.

Clients dismissed for non-payment may return once balances are resolved or a payment plan is arranged.

Initials: _____

Client Rights & Responsibilities

You have the right to respectful, nondiscriminatory care; to ask questions; to participate in treatment planning; to consent or refuse treatment; and to request records as permitted by law.

You are responsible for providing accurate information, participating in sessions, following safety plans, and meeting financial obligations for services.

Initials: _____

Acknowledgment & Agreement

I acknowledge that I have read, understand, and agree to the policies and consents contained in this Intake Packet, including Consent for Treatment, HIPAA Privacy Practices, Financial Agreement, Credit/Debit Card Payment Consent, Insurance Policy, Appointment & Cancellation Policy, Telehealth Consent, Termination Agreement, Minor Client policies (if applicable), and Client Rights & Responsibilities.

Client Signature: _____ Date: _____

Witness/Staff Signature: _____ Date: _____

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