GUILFORD COUNSELING, PLLC
(336) 337-5469
2100 West Cornwallis Dr., Ste. O GREENSBORO, NC

CLIENT INFORMATION

First Name | Middle | Last | Date of Birth (MM/DD/YYYY)

Address | City | State | Zip Code -

Emergency Contact Name | Emergency Contact Ph. Number | Relationship to Client

BILLING INFORMATION (Person responsible for payment)

First Name | Middle | Last

Relationship to Client
☐ Self ☐ Legal Guardian ☐ Other

Address (If different from above) | City | State | Zip Code

Phone / Email Address (Please list any phone numbers or email addresses we may utilize to contact you) May we leave a message?

☐ Home ☐ Mobile ☐ Work ☐ Other ☐ Yes ☐ No
☐ Home ☐ Mobile ☐ Work ☐ Other ☐ Yes ☐ No
☐ Home ☐ Mobile ☐ Work ☐ Other ☐ Yes ☐ No
☐ Home ☐ Mobile ☐ Work ☐ Other ☐ Yes ☐ No
☐ Home ☐ Mobile ☐ Work ☐ Other ☐ Yes ☐ No

REQUIRED SIGNATURES

I clearly understand that I am ultimately responsible for payment to Guilford Counseling, PLLC for any and all services rendered and that such payment is due ***at the time of the visit.*** *I also understand that if I suspend or terminate services, any outstanding balance will be immediately due. I understand that if I should default on any payment obligations as called for in this agreement, Guilford Counseling, PLLC will have the right to forward my information to a collection agency and up to an additional 30% will be assessed to my account to cover the costs of this action. Guilford Counseling, PLLC will not be obligated to provide continuing services to any client who includes Guilford Counseling, PLLC as a creditor in any bankruptcy filing. My signature below indicates that I fully understand and agree to these terms.*

Billing Signature (Required) Date
(Person responsible for payment)

My signature below indicates that I am consenting to treatment/services at Guilford Counseling, PLLC. I have received and understand and consent to the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPAA), the Electronic Communications Agreement, and the specific policies of my counselor. This information has been explained or summarized for me and any questions or concerns I had have been addressed.

Signature(s) (Required) Date(s)
(Client(s) or Legal Guardian(s))

I authorize Guilford Counseling, PLLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Guilford Counseling, PLLC. I understand that I am responsible for payment for services rendered by Guilford Counseling, PLLC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Guilford Counseling, PLLC immediately whenever there are changes in the client's health condition or health plan coverage in the future.

Signature (Required to Bill Insurance) Date
(Responsible Insured)

INSURANCE INFORMATION

We are in-network with several insurance companies. If we are in network with your insurance company, as a courtesy to you, we will work directly with them in an effort to collect reimbursement allowed by your benefits.

- We will verify your insurance benefit coverage and obtain any necessary authorizations for you. **Verification of benefit coverage is not a guarantee of claim payment.** All benefits are subject to the terms and conditions outlined in your contract with your insurance company. We have no authority to make representations to you regarding coverage of items or services covered.

- It is important that you understand your benefit coverage. For benefit coverage questions, please call the customer/member service phone number on the back of your insurance card. **It is your responsibility, prior to your first appointment, to verify your plan's limitations, deductibles and exclusions.**

- In compliance with health insurance contracts, Guilford Counseling, PLLC requires that all co-payments are collected at the time of service. This includes payments towards co-insurance and deductibles. In some cases the co-insurance/deductible amount collected will be an estimate and adjustments will be made once a response is received from your insurance company regarding the claim. This may result in a credit to your account or additional charges. **We do not have the option to waive co-payments, deductibles or co-insurance amounts due** as that would be a violation of the contract we have with the insurance company.

- It is your responsibility to pay the full fee for services at the time they are rendered, unless we have participating providers in your insurance plan. **You must provide your insurance card at your initial appointment** so that we may keep a copy in your record in accordance with our contract with the insurance company. You will receive an Explanation of Benefits (EOB) from your insurance company detailing charges, amounts you are responsible for and amounts they have paid.

- It is your responsibility to provide us with updated information if your insurance company or plan changes or your coverage terminates. It is also your responsibility to notify us of any changes in address or other contact information. If the insurance information you provide to us is later determined to be inaccurate resulting in a denial of your claim, you will be responsible to pay the amount denied by your carrier.

- It is your responsibility to pay any charges not eligible and/or not covered by your insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

- We store your credit card information **in a secure, HIPAA-compliant platform. Once entered, your credit card number is not visible to any Guilford Counseling employee.**

- Because we are a “fee for service” provider, we do not automatically send billing statements when there is an amount due. Should you need a statement or payment itemization, please request one from your therapist.

PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION			PRIVATE PAY
Insurance Co.			Insurance Co.			$ /INTAKE
Co-Pay: $	*Deductible: $	Co-Insurance: %	Co-Pay: $	*Deductible: $	Co-Insurance: %	$ /FOLLOW-UP

*** A DEDUCTIBLE Requires a Credit Card on File**

☐ VISA ☐ MasterCard ☐ DISCOVER	Card Number	Exp. Date	CVV Code

I hereby give consent to charge the credit card indicated for any outstanding balance as a result of deductibles, co-payments, co-insurance, or other amounts due according to this agreement and information provided by my insurance company.	Card Holder Name	
	Signature	Date

COUNSELING INFORMATION & POLICIES

Guilford Counseling, PLLC is a private practice of mental health professionals dedicated to providing counseling services that provide hope, healing, and transformation to individuals and families.

- Counseling (also referred to as therapy throughout this document) provides the opportunity for change, growth and self-discovery in the context of a safe, supportive, and therapeutic relationship. The process of change will, in many ways, be unique to your particular situation.
- Initial counseling sessions will involve an evaluation of your needs. The goal of this initial assessment is to provide you with some first impressions of what our work will include and a plan to follow.
- At any time you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling.
- Counseling can have benefits and risks. While benefits are expected from the counseling process, specific results cannot be guaranteed.
- If at any time during counseling you have questions about the effectiveness of the process, feelings about something your therapist has said or suggested or need clarification of our goals, do not hesitate to bring this up in your session.

CONFIDENTIALITY

The staff and therapists at Guilford Counseling, PLLC have an obligation to respect your right to confidentiality concerning the information you share within this clinical setting. Confidentiality of client information is governed by federal law (Health Information Portability and Accountability Act) and by state law.

The laws of the State of North Carolina impose some limitations to your rights of confidentiality. The following is a list of situations where we are either permitted or required to disclose information:

- You provide consent to release information.
- You disclose any maltreatment of minors or vulnerable adults. This includes physical abuse, sexual abuse or neglect.
- You disclose information regarding prenatal exposure to controlled substances.
- We have a reasonable suspicion that you are a threat to yourself or others.
- We are ordered by the court to disclose information.
- You involve an employee of Guilford Counseling, PLLC in a lawsuit and we are required to release specific information in order to received compensation for services rendered.
- We are required to share information with licensing boards in response to a disciplinary proceeding involving a provider.
- We are otherwise required by law to release information.

In addition, there are specific situations that require your consent that are necessary for our therapists to best perform their professional duties. Your signature on this agreement provides consent for those activities which may include:

- Consulting with other professionals about your case (while making every effort to not reveal the identity of the client)
- Sharing protected information with administrative staff for scheduling, billing and quality insurance purposes (all staff are bound by the same rules of confidentiality.
- Consulting with other businesses who, under contract, promise to maintain confidentiality of all data they come into contact with.

Minors have a limited right to privacy in that their parents may have the right to access their records. However, if the therapist believes that sharing this information will be harmful to you, confidentiality will be maintained within the limits of the law.

Group Therapy: The right to confidentiality is addressed in the group setting. Guilford Counseling, PLLC and group therapists are not responsible for any breaches of confidentiality by group members.

APPOINTMENTS

We realize that, on occasion, you may not be able to make a scheduled appointment. Please notify us via phone (leaving a voice mail if we do not answer) as soon as possible if you will need to cancel or re-schedule an appointment.

Please remember that your appointment time has been reserved for you alone so **our policy is to charge the full fee for missed or canceled appointments if you do not provide 48-hour advanced notice.**

Because we usually have many people on our waiting list, clients who frequently cancel, re-schedule, or miss appointments, especially without giving 48-hour notice, will not be allowed to retain a regularly scheduled appointment time and may be placed on the waiting list.

Successful therapy requires a commitment on the part of the client. *It is important that you keep your appointment if at all possible.*

AFTER-HOURS EMERGENCIES

For after-hours emergencies or if you need immediate assistance, call 911 or visit your local emergency room, medical group or primary physician.

Guilford Counseling, PLLC cannot guarantee that a therapist will be available to handle emergencies. Our therapists are normally not available after usual business hours. You may leave your therapist a message and they will return your call as soon as possible, usually within 24 business hours.

Some Crisis Numbers Include:

Police emergency 911

Cone 24 hour HelpLine 336-832-9700 or 800-711-2635

TELEPHONE CONSULTATIONS

An initial phone consultation is offered at no charge in order to answer your questions about counseling, insurance, fees and Guilford Counseling, PLLC as well as arranging an appointment. Once therapy has begun, telephone conversations lasting longer than 10 minutes may be charged at a prorated hourly rate.

PREPARATION OF FORMS AND REPORTS

The preparation of forms and reports require chart review, clerical time and often, discussion with the client. The charge for this service is $150 per hour with a minimum charge of $20.

PAYMENTS

Guilford Counseling, PLLC accepts cash, personal checks, as well as the following credit cards for payment: Visa, MasterCard, Discover, American Express. If mailing, please remit payment to: Guilford Counseling, PLLC
430 Battleground Ave.
Greensboro, NC 27401

CHECK POLICY

To ensure proper credit, please make checks payable to **Guilford Counseling, PLLC**

There is a $25 fee for returned checks. Thereafter only cash, money order or credit card will be accepted for payment.

FEES

FEES (These fees may be changed at our discretion. You will be notified in writing of any changes)

Important Note: These are our customary fees. If you intend to utilize insurance benefits, your actual cost out of pocket may be substantially less depending on your coverage. In addition, reduced fees are offered for those without insurance coverage or based on financial hardship. Please contact us for a free initial consultation to determine what your out of pocket expenses might be.

Insurance Code	Description	Time Alotted	Charge
90791 - 90853	Intake, Individual, Group, or Family Therapies	20-60 Minutes	$55 - $150
Not Billable to Insurance	Late Cancellation / No Show	n/a	$50
Not Billable to Insurance	Returned Check	n/a	$25
Not Billable to Insurance	Phone Calls (over 10 min.), Letters, Forms, etc.	Varies	$150/hr. ($20 min.)
Not Billable to Insurance	Court Appearances and Preparation	60 Minutes	$250.00/hr.
Not Billable to Insurance	Professional Consultation Services	60 Minutes	$200.00

All information regarding clients is confidential and will not be released without your written consent. If a request for transfer of records is made, they will be forwarded upon completion of a consent form and payment of a fee based on the current NC Dept of Health maximum allowed. Copies of records are available for $.75 per page (first 25 pages), $.50 (pages 26-100) and $.25 (pages 101+) with a minimum charge of $10

CLIENT BILL OF RIGHTS

Guilford Counseling, PLLC does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability or public assistance status. Every client:

- Has a right to receive treatment, including access to medical care and habilitation, regardless of the age/degree of disability.
- Has the right to consent to or refuse any treatment offered or suggested.
- Has the right to confidentiality and privacy (see Confidentiality section for exceptions). Generally, no one will learn of our work together without your written consent.
- Shall be informed prior to, or at the time of, the intake appointment of services available at Guilford Counseling, PLLC and any financial charges that are the client's responsibility to pay beyond the coverage of health insurance.
- Can expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
- Shall have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his or her treatment.
- Shall have the freedom to place grievances and recommend changes in policies and services to the staff of Guilford Counseling, PLLC free from restraint, interference, coercion, discrimination, or reprisal.
- Has the right to be informed of, and to refuse to participate in, any experimental research.
- May expect courteous and respectful treatment by Guilford Counseling, PLLC staff.
- Has the right to a coordinated transfer of care when there will be a change of providers.
- May assert their client rights without retaliation.
- Has the right to choose freely among available mental health professionals in the community and to change providers after services have begun within any contractual limits of the client's health insurance.

In addition to the rights listed above, clients utilizing services offered by practitioners licensed by the State of North Carolina have the right to: (a) expect that a practitioner has met the minimal qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; (c) obtain a copy of the rules of conduct.

EMERGENCY MEDICAL TREATMENT PREFERENCE

It is the policy of Guilford Counseling, PLLC that, if there is an emergency with you in our building and/or in session, we will call 911 and request an ambulance. We will also call the emergency contact person that you listed previously. At the arrival of the ambulance, we will give them the following information:

Hospital Preference:

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Current Primary Care Physician: ______________________ Phone: ______________________

Allergies/Special Health Considerations:

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NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how your protected health information (PHI) may be used and disclosed and how you can access this information. Please review it carefully. Protecting our clients' privacy is important to this practice. The Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At Guilford Counseling, PLLC we are very careful to keep your health information secure and confidential.

This law requires us to maintain your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care.

- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. You have the right to restrict the disclosure of PHI to your insurance company if you pay for services in full.
- We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer. Use and disclosure of your PHI for marketing purposes and the sale of PHI is not allowed without your written authorization.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- Uses and disclosures of the separate Psychotherapy Notes (described in our disclosure) require your written authorization.
- We may use your information to contact you and we will use whatever address or telephone number you prefer. For example, we may need to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may also send you automatic email reminders for your appointments. You have the right to opt-out of these emails.
- We may release some or all of your health information when required by law. Sale of your PHI to third parties is prohibited.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- You have the right to transfer copies of your health information to another practice.
- You have the right to see or receive a copy of any of your health information and can request, in writing, an amendment or change to your health information. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- We utilize electronic systems to store some of your PHI. Should a breach in security occur, we are required to notify you within 60 days of the occurrence of said breach.
- You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You have the right to file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. Before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Clinical Director, Jennifer Cobb at guilfordcounseling@gmail.com or 336-337-5469.

ELECTRONIC COMMUNICATION AGREEMENT & AUTHORIZATION

Risk Factors

Among general Electronic Communication (including, but not limited to Email and Texting/SMS) risks are the following:

- These communications can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Recipient can forward messages to other recipients without the original sender's permission or knowledge.
- User can easily misaddress an electronic communication.
- Electronic Communication is easier to falsify than handwritten or signed documents.
- Backup copies of electronic communications may exist even after the sender or the recipient has deleted his or her copy.

Conditions for the Use of Electronic Communication (hereafter referred to as EC)

It is the policy of Guilford Counseling, PLLC that all representatives of Guilford Counseling, PLLC will make all EC sent or received that concern the diagnosis or treatment of a client part of that patient's medical record and will treat such messages with the same degree of confidentiality afforded other portions of the medical record. Guilford Counseling, PLLC will use reasonable means to protect the security and confidentiality of EC information.

Because of the risks outlined above we cannot, however, guarantee the security and confidentiality of EC. Thus, clients must authorize the use of EC for discussions of confidential medical information after having been informed of the above risks. Consent to the use of EC includes agreement with the following conditions:

1. All EC to or from the patient concerning diagnosis and/or treatment will be made a part of the client's medical record. As a part of the medical record, other individuals, such as other physicians, nurses, physical therapists, patient account personnel, and other entities, such as other healthcare providers and insurers, will have access to EC messages contained in medical records.
2. Guilford Counseling, PLLC may forward ECs as necessary for diagnosis , treatment, and reimbursement. Guilford Counseling, PLLC will not, however, forward the ECs outside of necessity without the consent of the client or as required by law.
3. If the client sends an EC to Guilford Counseling, PLLC, another healthcare provider, or an administrative department, Guilford Counseling, PLLC will endeavor to read and respond to the EC promptly, if warranted. However, Guilford Counseling, PLLC can provide no assurance that the recipients of a particular EC will read the message promptly. Because Guilford Counseling, PLLC cannot assure clients that recipients will read EC promptly, **clients must not use Electronic Communications in a medical emergency**.
4. If a client's EC requires or invites a response, and the recipient does not respond within a reasonable time, **the client is responsible for following up to determine whether the intended recipient received the EC and when the recipient will respond.**
5. Because employees do not have a right of privacy in their employer's EC systems, clients should not use their employer's EC systems to transmit or receive confidential medical information.
6. Guilford Counseling, PLLC cannot guarantee that ECs will be private. Guilford Counseling, PLLC will take reasonable steps to protect the confidentiality of client ECs but is not liable for improper disclosure of confidential information not caused by Guilford Counseling, PLLC's gross negligence or wanton misconduct.
7. If the client consents to the use of EC, he/she is responsible for informing Guilford Counseling, PLLC of any type of information the client does not want to be sent by EC. Client is responsible for protecting his/her password or other means of access to ECs sent or received from Guilford Counseling, PLLC to protect confidentiality. Guilford Counseling, PLLC is not liable for breaches of confidentiality caused by client.
8. Any use of EC by the client that discusses diagnosis or treatment by the client constitutes informed consent to the foregoing. You may withdraw consent to the use of e-mail at any time by email or written communication to Guilford Counseling, PLLC.
9. Being informed of these risks, clients who choose to utilize EC with Guilford Counseling, PLLC thereby communicate their authorization for such communication, including replies from Guilford Counseling, PLLC.

By signing the consent to treatment/services on page 1, you signify that you fully understand and agree to the terms of this Electronic Communication Agreement.