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Symptom Checklist

Client Name: _____ Date: _____

Please check all items that apply to you. You may add notes and details on the back.
All this information is strictly confidential.

- I have no problems or concerns
- Aggression, violence
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Career concerns, goals, choices
- Childhood issues (your own childhood)
- Children, child management, child care, parenting
- Concentration, distractibility, disorganized thoughts, confusion, memory problems
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Eating problems – overeating, under eating, appetite, vomiting, weight issues
- Fear of failure, or sensitivity to criticism
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses
- Guilt
- Hallucinations (hearing voices, seeing things)
- Health, illness, medical concerns, physical concerns, chronic pain
- History of abuse (physical, sexual, emotional)
- Homicidal thoughts or gestures (now- in past)
- Inferiority feelings, feeling worthless
- Impulsiveness, loss of control, outbursts
- Judgment problems, risk taking, irresponsibility
- Loneliness
- Mood swings
- Motivation
- Obsessions, compulsions (thoughts or actions that repeat themselves
- Panic or anxiety attacks
- Perfectionism
- Pessimism, or feelings of hopelessness
- Procrastination, work inhibitions
- Relationship problems
- School or academic problems
- Self centeredness
- Self esteem
- Self neglect, poor self care
- Sexual issues
- Sleep problems – too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Stress, relaxation, stress management, stress disorders, tension
- Substance abuse – alcohol, prescription medication, over the counter medications, street drugs
- Suicidal thoughts or gestures (now or in the past
- Temper problems, self control, low frustration tolerance
- Withdrawal, isolation

Any other concerns or issues:_____

What is your proudest accomplishment?_____

What are your strengths?_____

What are your family's strength's?_____

Please look over the items you checked and choose the one that you most want help with at this time. _____

Have you received any previous psychological services? If yes, please indicate when, where and from whom you received services._____

Are you currently taking medication? If yes, please indicate what, how long, and for what reason._____

List any additional details for checked items _____

Please provide any information that you feel may be helpful

231 North Spring Street, Greensboro, NC 27401 **PH** 336.899.8800 **FAX** 336.899.8811
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APPOINTMENT REMINDER CONSENT

I, _____ give Family Solutions, PLLC permission to call me
Client Name (Print)

prior to an appointment to remind me of the appointment date and time.

_____ **YES**, please contact me by:

*(Please choose **ONE** preferred contact method)*

☐ Voicemail at my Home ☐ Voicemail on my Cell

_____-_____-_____ _____-_____-_____

☐ Text message ☐ Email: _____

_____-_____-_____ Please print your email address legibly.

_____**NO**, I do not give my consent.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am receiving services at Family Solutions until I withdraw my consent during treatment.

_____ _____ _____
Client Signature Client Name (Print) Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

Assigned Therapist:_____

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FEE AGREEMENT AND FINANCIAL POLICY

Please review this Fee Agreement and Financial Policy, which describes our schedule of fees for services, charges not covered by insurance, and no-show/cancelation policy. Please be sure you understand the policies regarding cancellations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. **Please ask your therapist any questions prior to signing this Agreement and Policy.**

Our service rates and health insurance billing codes:

- 90791 Comprehensive Clinical Assessment – (60 min.) $120.00
- 90837 Individual Therapy (53 min.) $100.00
- 90834 Individual Therapy (38 min.) $80.00
- 90832 Individual Therapy (16 min.) $60.00
- 90846 Family Therapy w/out client present (53 min.) $100.00. (This code is sometimes not covered by ins.)
- 90847 Family/Couples Therapy (53 min.) $100.00
- Actual in-network contract rate may be lower than rates listed above.
- Rates above apply for out-of-network insurance and self-pay clients.

CHARGES NOT COVERED BY INSURANCE

- Medical Records Requests- see fee schedule/details on Court & Record Prep Form.
- Case Management* $75 per hour (pro-rated per 10 min.)
  *Case Management includes indirect services I provide outside our session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), school consultation, coordinating adjunct and court advocacy services, and completing forms or reports. See form "Notice of Rates for Court Appearance and Record Preparation Related Services" for more details on court related charges.
- Phone Consultations lasting more than 10 mins. $75 per hour (i.e. mins.11-60 are pro-rated per 10 min.)

ADDITIONAL FEES

- Late Cancellations/No-Show Appointment – fewer than 24 hrs. prior to appointment $40.00
- Non-sufficient funds (bounced) check $25.00
- Past-due accounts – over 60 days $25.00 per month added to current balance

PAYMENT

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services are provided. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to: *Family Solutions.*

INSURANCE REIMBURSEMENT AND AGREEMENT

Family Solutions accepts and processes insurance payments through some insurance providers. If you are using your insurance to pay for our services, then we will:

(1) Expect and accept payment of your copayment, co-insurance or self-pay fee amount at the time of service;
(2) File your claim with the insurance provider;
(3) Receive payment from your insurance provider;
(4) If there is a credit on your account, you will be provided a refund promptly or can be applied to future charges

Family Solutions files insurance as a courtesy to you, and that you (not your insurance company) are ultimately responsible for your bill. If your insurance company denies a claim filed on your behalf, then you are responsible to pay Family Solutions for the difference between the standard rate and the amount previously paid as copay unless approved otherwise by owners of Family Solutions. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

I agree to (1) allow Family Solutions to bill my insurance directly for services provided under the Outpatient Services Agreement; (2) give Family Solutions permission to release any information the insurance company may require in order to process payment; appoint Family Solutions as my authorized representative to act for me in obtaining payment; (3) assign all of my rights to claims and payment by my insurance to Family Solutions; and (4) agree to assist with the claims process as required by Family Solutions or my insurance provider. I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt within psychotherapy are reimbursed by insurance companies.

CANCELLATIONS & MISSED APPOINTMENTS

Insurance companies will not pay for late cancellations, missed appointments or no-shows. Once an appointment is scheduled, that time slot is reserved specifically for you. Cancellations must be made at least 24 hours in advance. Although 24 hours is the minimum, if you need to cancel or reschedule please give as much notice as possible. You may notify our office of cancelation by phone or email to your provider.

- Late cancellations or no-shows (fewer than 24 hours before the appointment) will incur a fee of $40.00.
- Three no-shows or cancellation less than 24 hours during a two month period or 2 consecutive no-shows or cancellations less than 24 hours will result in discharge from our practice.

PAST DUE ACCOUNTS

Amounts past due by more than 60 days will incur a late fee each month of $25.00. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Family Solutions may resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, you will be responsible for those costs.

I have read the entire Agreement and Policy stated above, and I have been offered a copy for my records. I understand the policy and by my signature below, I agree to be bound by its terms in association with outpatient therapy services provided to me by Family Solutions. Any and all negotiated exceptions or special arrangements are listed below and require approval and are not valid unless signed by a representative of Family Solutions.

Client Name (printed) **Client /Guardian Signature** **Date**

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Credit Card Form for Self-Pay and Private Insurance

Upon scheduling your first appointment, we ask that you please provide information from an active credit card for Family Solutions to keep on file. This will be kept on file electronically with the same program used to store and secure our confidential medical records. Once transferred to our secure electronic database, all hard copies of this document will be destroyed and not kept in the client's physical file. This information is meant to be used as a form of payment for potential fees incurred for co-pays, co-insurance, deductibles, late cancellations, missed appointments, returned checks, or past due account balances. A receipt will be emailed to you or by request can be mailed to you.

Type of card (circle one):

☐Visa MasterCard ☐American ☐Express Discover

Card # : ____ ____ ____ ____- ____ ____ ____ ____ -____ ____ ____ ____-____ ____ ____ ____

Expiration: _____

Security code:_____

Name on card: _____

Email Address if you want receipt: _____

I authorize Family Solutions to charge this credit card as needed according to the terms specified in this Agreement and Policy.

Signature: _____ **Date:** _____

Client Name:_____

Therapist Name:_____

*Family Solutions Therapist: Please scan *just this page* to Megan so she can have on file and make charges when appropriate.

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Family Solutions Consent for Service

Client Name: _____

- I hereby give my consent for treatment and/or services to be provided to the above-named person by the staff of Family Solutions and I acknowledge that I have received a copy of my rights as a client.
- I hereby give my consent/authorize Family Solutions to contact my PCP and/or other approved medical provider for a service order in case additional sessions need to be authorized if deemed medically necessary.
- I hereby give my consent/authorize Family Solutions to seek emergency medical care from a hospital or physician. *If you do not want Family Solutions to seek emergency medical care please note reason at the bottom of this form.

Client Signature Date

Parent or Guardian Signature Date

Emergency Contact Information

Please provide us with an emergency contact below. Contacts will be notified *only* if a emergency occurs while on the premises of Family Solutions.

In case of emergency, please contact:

Name Telephone # Relationship to You

Primary Care Physician (PCP) Information

Please provide us with the name, address, and telephone number of your primary care physician (PCP). Your signature above authorizes Family Solutions to contact your PCP or an approved medical provider to help coordinate services and/or for a service order in case additional sessions are needed if deemed medically necessary.

Name: _____ Telephone # : _____

Address: _____

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Notice of Rates for Court Appearance and Record Preparation Related Services

DEPOSITION OR COURT APPEARANCE: If a Therapist from Family Solutions, PLLC (a private practice) is required to appear in a legal proceeding for a current or former client there will be a $200.00 minimum scheduling fee which is payable at the time the subpoena is delivered. If the fee is not paid at that time, arrangements for payment are the duty of the party requesting the appearance and must be rendered prior to any appearance. The fee is due whether or not the Therapist is actually called on to testify that day. The fee is due even if the appearance is canceled by anyone other than the Therapist for any reason and at any time.

If a Family Solutions, PLLC Therapist testifies in any court or legal proceeding, voluntarily or by subpoena or court order, regardless if the testimony is factual or expert, or to present any or all records pertaining to the therapy relationship to a court official, the client agrees to pay Family Solutions, PLLC for these testimony related services (including but not limited to: travel, necessary expenditures such as copies, parking, meals, and the like, time spent speaking with attorneys, reviewing records and preparation or reports) at the rate of $100 per hour.

Further required attendances by the Therapist will be charged at additional daily rates under the same conditions. These terms are not negotiable. A $100.00 fee is assessed for every hour, or portion of an hour, of the Therapist's time away from our office located at 231 North Spring Street, Greensboro, NC. The Therapist has cancelled regularly scheduled appointments in order to serve you or your family needs in court. If you, your attorney, or the hearing official has canceled the scheduled Therapist court appearance it is too late for the Therapist to reschedule their client hours. This charge is not covered by insurance or Medicaid. As a client of Family Solutions, PLLC, it is your responsibility to inform your legal counsel of this notice and the associated charges.

PREPARATION OF FORMS AND REPORTS: These require chart review and often, discussion with the client and/or legal counsel representing client. There will be a minimum charge of $25 up to a maximum of $100 per hour. Copies of medical records will be made available for a $20.00 processing fee, plus $1.00 per page for copying.

_____ _____

Signature of Client, Parent or Guardian Date

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CLIENT NOTIFICATION

CLIENT NAME: _____ FS RECORD # : _____

MENTAL HEALTH # : _____

I. CLIENTS RIGHTS AND GRIEVANCE PROCEDURE AND POLICY INFORMATION:
A detailed description of rights of clients and grievance procedure and policy in contracted facilities of the Local LME (Local Managed Entity) MH/MR/SA Program has been provided to me as well as any possible restrictions. Along with the explanation of rights and restrictions, I have had the opportunity to ask questions. Signature below indicates my receipt of both verbal and written explanation of client rights in this facility.

II. NOTICE TO CLIENT RELATING TO CONFIDENTIALITY:
This is to notify you that state and federal laws protect the confidentiality of your information as a client in this facility and allow for release of information only with your written consent or otherwise as the law may require or permit. There may be instances in which pertinent information may be disclosed without your express written consent such as medical emergencies or in assuring you receive appropriate continuing care (for example, to a hospital, Guilford/Randolph County D.S.S. or Public Health). Further details will be explained at your request.

The foregoing NOTICE has been received in writing. Signature below indicates my understanding of the NOTICE, agreement that information disclosures should be made under such conditions, and acknowledgement of receipt of written notice.

_____

SIGNATURE of Client or Legally Responsible Person DATE

_____

SIGNATURE of Employee Furnishing INFORMATION and NOTICE DATE

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CLIENT RIGHTS

As a client, you have many rights. Understanding your rights will help you get the best possible care. Knowing you rights can help you make better decisions about your care and resolve any problems that may occur. You always have the right to ask questions and get the information you need to make the best decision for you.

It is your right to:

- **Be informed of your rights.** By law, we must inform you of all of your rights within the first three visits to our program. You have the right to ask that printed information explaining your rights be given to you in a way that you can understand. You have the right to know what to do and who to call if you believe someone is trying to take away your rights (please see advocacy list).
- **Know what is expected of you.** We must let you know about any rules that you need to follow. This information should be shared with you when you begin receiving services. If this does not happen, ask a staff member.
- **Get the best services possible.** You should receive the best care possible from professionals who care about your needs.
- **Always be treated with respect.** Employees should be courteous, attentive, and sensitive to your needs and values.
- **Confidentiality.** Medical records, treatment plans, and any other information about you (including what you say or share) must be kept confidential (See HIPAA Privacy Notice for more detailed information). To be given this information, anyone not directly involved in your care, including family members, must first have your permission. By law, there are some situations when information about you may be shared without your permission. These include:
  - When it is in your best interest and it will not be harmful to you, your closest relative or guardian may be informed that you are a client. If you are under 18 years old, your parent or guardian may be informed that you are a client.
  - Right to release minimal information necessary.
  - When a client advocate who is helping you needs to review your record.
  - When we are ordered by the court to release your record.
  - If our attorney needs to see your file because of a lawsuit or other legal action.
  - If you have been committed to an institution and we need to share information about you in order to manage your care.
  - If we transfer your care to any other county mental health program or state facility.
  - If you are in prison and your record needs to be shared with prison officials to continue your treatment.
  - If you have an emergency, we may need to share information with another professional who is treating you.
  - If a physician or other professional who referred you to our program needs information.
  - If you are a danger to yourself or others or if we believe that you will commit a serious legal offense or become violent.
  - Right to an accounting of released information.
  - Your confidentiality is protected at Family Solutions by two laws NC G.S. 122C52-56 and 164.512 of HIPAA.
- **Informed consent.** This means having all of the information you need before you make a decision about your care. Except during an emergency, informed consent is always your right. Before you give your approval for any service or treatment, be sure you have all of the information you need. This includes understanding your service plan and your choices. It is your right to be involved in developing and reviewing your service plan. This plan must be in use no later than 30 days after your services start. Before you agree to your plan, you must be informed of the advantages and risks of the services you receive. You must also be informed about all of the different kinds of services that are available to you through Family Solutions and the local MCO.
- **Accept or refuse services.** By law, you can accept or refuse any procedure, medication, test or treatment with Family Solutions. The only times you can be treated without your permission are during an emergency if you give signed permission, when it is court-ordered, or if you are under 18 years old and your parent or guardian has given permission. In addition, you have the right to treatment, including access to medical care & habilitation, regardless of age/degree of disability. Refusal of consent will not be used as the sole grounds for termination or threat of termination of services unless the treatment offer is the only viable treatment option available at your agency.

- **Review your medical records.** In general, you have the right to review information in your medical records, which includes your treatment service plan. Please contact your therapist if you would like to receive a copy of your treatment plan. The only time you cannot see your records is if more that one professional determines that it would be harmful for your or someone else.
- **Know the costs for services.** Fees for services should be discussed with you at your first visit. See agreement to pay form.
- **Take part in discharge planning.** A discharge plan provides recommendations for your care after you complete your treatment with Family Solutions. Be sure to discuss what your needs are with a staff person before leaving the agency.
- **Be accepted for treatment.** Your services cannot be denied, interrupted, or reduced without good cause. If you are a Medicaid client (or if you are eligible to be one) and your treatment is denied, interrupted, reduced, or stopped, you can appeal the decision by following instructions given to you when you are notified of the change in services.
- **Be aware of when seclusion and restraints are allowed.** Family Solutions does not use seclusion and restraints.
- **Be aware of search and seizure.** All clients receiving services at Family Solutions shall be free from unwarranted invasion of privacy. Should a situation arise where the safety of the client or others in the agency is in question, local law enforcement agents will be immediately involved.
- **Make a complaint.** You may obtain a copy of the Grievance Procedure from your counselor, or any other staff member. We will assist you in understanding and following the grievance procedure upon your request. You can also contact any of the advocacy groups listed below, including Disability Rights NC, the statewide agency designated under Federal and State law to protect and advocate for the rights of persons with disabilities. In addition, you are also free to contact your respective MCO and file a complaint. Here are numbers for the MCO that we are a member of: Sandhills MCO (910) 673-9111; Cardinal MCO (800) 939-5911. If your complaint involves physical or sexual abuse, you should call the Department of Social Services (DSS) at 373-3701 or 373-3123.
- **Contact an advocate.** Advocates can help to protect your rights and resolve conflicts. Listed below are a few of the organizations you can call to get in touch with an advocate:

- Mental Health Association in Greensboro, 373-1402
- Mental Health Association in High Point, 883-7480
- Disability Rights NC, 1-877-235-4210
- NC Mental Health Consumer's Organization, 1-800-326-3842
- NC CARELINE, 1-800-662-7030
- NAMI Guilford County, 370-4264
- NAMI North Carolina, 1-800-451-9682

Family Solutions After-Hours Emergency Coverage

If you are in crisis (emergency mental health) during regular hours, please call **336-899-8800**. If it is after business hours (9:00am–5:00pm, M-F), or on a weekend or holiday, and cannot wait until the next business day, you can speak with an on-call staff person by calling **(336) 899-7110**.

Identify yourself as a client receiving services from Family Solutions and the on-call staff person will discuss your crisis and provide you with options. The on-call person may direct you to seek immediate assistance through one of the sources listed below:

- **For life threatening emergencies: DIAL 911**
- **Crisis line for domestic violence, rape, or sexual assault:**
  336-273-7273 from Greensboro; 336-889-7273 from High Point; or 336-629-4159 from Randolph County.
- **Face-to-face assessment or psychiatric hospitalization in Greensboro:**
  Monarch Emergency Services - 24/7 Coverage, 201 N. Eugene St., GSO; Phone 336-676-6840.
  Moses Cone Behavioral Health Assessment, 700 Walter Reed Drive, GSO, Phone 336-832-9700.
- **Face-to-face assessment or psychiatric hospitalization in High Point:**
  RHA Behavioral Health Services, 211 S Centennial St., High Point, NC 27260, Phone 336-899-1505, *(Only during normal business hours).*
  High Point Regional Hospital, 601 N. Elm St., High Point, Phone 336-878-6000 press 1 then extension 2976.*(Nights and weekends).*
- **Face-to-face assessment or psychiatric hospitalization in Randolph County:**
  You can contact one of three facilities: Moses Cone Behavioral Health Assessment, High Point Behavioral Health/Assessment Center, or Emergency Department at Randolph Hospital, 364 White Oak Street, Asheboro, Phone: 336-625-5151 then press extension 3229.
  Please identify yourself as a current Family Solutions client and who is your current therapist is.

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164) the federal drug and alcohol confidentiality law (42 C.F.R. part 2) and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122 C), and confidentiality governing HIV/AIDS status (G.S. 130A-143).

Client's Name: _____ FS Record Number: _____

Date of Birth: _____

I, _____ authorize **Family Solutions**

Name of client or client's legally responsible person *Agency or person authorized to use and disclose the information*

to use or disclose to/with _____

Name of agency or person to whom the requested use or disclosure will be made (include address, if applicable)

THIS DATA SHALL INCLUDE *(client must initial beside data to be used or disclosed)*

_____ Assessments	_____ Service Notes	_____ Substance Abuse/Treatment (G.S. 122 C)
_____ Psychiatric Evaluations	_____ Service Plans/Goals	_____ HIV/AIDS Information (G.S. 130A-143)
_____ Psychological Evaluations	_____ Discharge Summary	_____ Social, Developmental, Medical History
_____ Diagnoses	_____ Financial/Reimbursement	
_____ Other: _____		

PURPOSE OF USE OR DISCLOSURE *(client must initial beside data to be used or disclosed)*

_____ At the request of the individual	_____ Assessment/Evaluation	_____ Coordination of Service
_____ Court Proceedings	_____ Determination of Benefits	_____ Other _____

Information requested should be mailed to this address: _____

_____

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C); or HIV/AIDS information (G.S. 130A-143); substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

_____ _____

Date of expiration, if less than one year ***Event, if less than one year***

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that Family Solutions, PLLC will

not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____ _____ _____

Signature of client **Date** **Staff Signature** **Date**

_____ _____

Signature of legally responsible person, if required **Date**

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