Grow Yourself Great Counseling and Consulting, PLLC

Email: admin@GYGCounseling.com
Telephone: (704) 313-0174
Fax: (800) 853-7998
Charlotte, North Carolina 28269

Consumer's Name:	**Date of Birth:**	**Record #:**
Legal Guardian:	**Insurance:**	**Policy #:**

CONSUMER CHOICE

This is to confirm that consumers and families are provided with information to make an informed decision about which provider they would like to choose to provide their needed services.

After given the opportunity to explore choices, the following service providers were chosen:

Provider Name: GYG Counseling & Consulting PLLC **Service:** Outpatient Therapy

Provider Name: _____ **Service:** _____

Provider Name: _____ **Service:** _____

Provider Name: _____ **Service:** _____

Provider Name: _____ **Service:** _____

Consumer's Signature: _____ **Date:** _____

Legal Guardian's Signature: _____ **Date:** _____

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CONSENT FOR SERVICES

(Consumer/Guardian initials each Item)

_____ We/I give consent for Grow Yourself Great Counseling and Consulting, PLLC (GYG) to provide services to myself/ my child/ my ward.

_____ We/I will participate in Outpatient Therapy Services and follow all treatment recommendations which address identified goals on my person-centered plan that I will work towards in time frames and methods to achieve the goals.

_____ GYG services have been described and we/I understand that my GYG workers will visit in my home, work, school or community to provide services that will help me reach my goals, if necessary and agreed upon by all parties involved.

_____ We/I have been explained about the benefits, risks and alternatives to planned services and the ways that GYG can support the achievements of the desired outcomes.

_____ Any fees or costs have been explained to us/me.

Consumer's Signature: _____ **Date:** _____

Legal Guardian's Signature: _____ **Date:** _____

GYG Staff's Signature: _____ **Date:** _____

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CONSUMER RIGHTS ACKNOWLEDGMENT

I, _____(Consumer/Guardian's Name) hereby acknowledge that I have read and understand the "Notification of Consumer Rights" and that these have been read and explained to me so that I understand them.

Consumer's Signature: _____ **Date:** _____

Legal Guardian's Signature: _____ **Date:** _____

★ ★

Complete this section if the Consumer is unable or unwilling to sign.

_____ (Consumer Name) has read his/her rights on _____

_____ (Date). These rights were reviewed, and explained by _____ (Staff Name).

Staff Name: _____ **Date:** _____

Witness Name: _____ **Date:** _____

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RIGHT TO CONFIDENTIALITY

You have the right for your confidentiality to be upheld within the limits of the law and to provide informed consent when information is released to another organization or individual outside GYG.

Your records will be released only with your consent or the consent of your authorized representative except by court order, in emergencies or as otherwise required or permitted by law.

You have the right to inspect and to have copies of your records at your own expense, except where it would be harmful to you. In that situation, a lawyer, doctor or psychologist you choose can see the records on your behalf. If you feel there are mistakes in your record, you can ask to have them corrected, and if the company doesn't change what you think is an error, you can place your statement about the error in your record.

Confidential information may not be disclosed without written consent when Federal Statutes prohibit that release. 42 CFR Part 2 Subpart D Disclosures Without Patient Consent General Statute 122C-52(d) No provision of G.S. 122C-205 and G.S. 122C-53 through G.S. 122C-56 permitting disclosure of confidential information may apply to the records of a client when federal statutes or regulations applicable to that client prohibit the disclosure of this information.

Consumer's Signature: _____ **Date:** _____

Legal Guardian's Signature: _____ **Date:** _____

GYG Staff's Signature: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES OF ACCG, PLLC

Grow Yourself Great Counseling and Consulting, PLLC must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of *Grow Yourself Great Counseling and Consulting, PLLC* to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care, and for other services relating to your health care.

The purpose of this *Notice of Privacy Practices* is to inform you about how your health information may be used within Grow Yourself Great Counseling and Consulting, PLLC, as well as reasons why your health information could be sent to other service providers outside of this agency.

This *Notice* describes your rights in regards to the protection of your health information and how you may exercise those rights. This *Notice* also gives you the names of contacts should you have questions or comments about the policies and procedures Grow Yourself Great Counseling and Consulting, PLLC uses to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Client Acknowledgement

I have read and understand the Grow Yourself Great Counseling and Consulting, PLLC's *Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.

Consumer's Signature: _____ **Date:** _____

Legal Guardian's Signature: _____ **Date:** _____

GYG Staff's Signature: _____ **Date:** _____

Note: Grow Yourself Great Counseling and Consulting, PLLC retains this signed page. Client retains the Notice of Privacy Practices document.

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AFTER HOURS CRISIS RESPONSE SERVICES

After business hours, during weekends and on holidays, Grow Yourself Great Counseling and Consulting, PLLC provides telephone crisis response, assessment, safety planning, and referrals for their clients. This service is accessed by phoning the Grow Yourself Great Counseling and Consulting, PLLC after hours on call Crisis Clinician at (**555) 555-5555**. All Grow Yourself Great Counseling and Consulting, PLLC clients may utilize this service to obtain immediate, telephone-based consultation and support regarding a variety of **crisis issues.**

Policy: Grow Yourself Great Counseling and Consulting, PLLC shall maintain after-business hours, during weekends and on holidays crisis response for all clients. One Grow Yourself Great Counseling and Consulting, PLLC staff will be on-call at a time rotating weekly. Crisis response shall be designed for prevention, intervention and resolution at the least restrictive level possible to ensure the consumer's safety.

If you have any questions about the After-Hours Crisis Response Services, please speak with any of the administrative staff or your therapist.

I have read and understand the After-Hours Crisis Response Services Policy.

_____
Client Name (Print)

_____ _____
Client Name (Signature) Date

If the consumer has a legal guardian:

_____
Parent/Legal Guardian (Print)

_____ _____
Parent/Legal Guardian (Signature) Date

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COURT APPEARANCES, SUBPOENAS AND EXPERT WITNESS TESTIMONY

-Preparation: **$100.00 per hour; billed in 15-minute increments**

-Travel: **$500/day flat rate for out-of-town travel not including lodging expenses**

-Time in court: **$200.00/hour**

-Supervised Therapeutic Visitation: **$200.00/hour** *(includes court summary)*

I have read the above, understand and agree with the provisions and associated fees of this policy.

_____
Client Name (Print)

_____ _____
Client Name (Signature) Date

If the consumer has a legal guardian:

_____
Parent/Legal Guardian (Print)

_____ _____
Parent/Legal Guardian (Signature) Date

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FEES AND INSURANCE

Grow Yourself Great Counseling and Consulting, PLLC (GYG, PLLC) appreciates you considering us as your mental/behavioral health provider. As a part of the delivery of mental health services, we have prepared important information about fees, insurance, client responsibilities and related polices. **PLEASE READ THIS CAREFULLY** and if you have any questions, please discuss them with us.

We accept the following insurance:

Blue Cross/ Blue Shield, United Behavioral Health, Aetna, Tricare, Medicaid, NC Health Choice, Self-Pay/Private Pay

As a courtesy, we file your insurance for you, but must have your full insurance information, including secondary insurances in order to do so. Payment for co-payments, co-insurance and deductibles are expected when services are rendered. If insurance payment is not received within ninety (90) days after a claim is filed, the client is then responsible for payment of the total amount due regardless of any outstanding secondary insurance payments. It is your responsibility to follow-up with your insurance company for delayed payments or other concerns.
While we try to avoid situations in which insurance coverage is expected but later denied, we cannot guarantee the service provided will be reimbursed. It is up to you to know your and/or your child's insurance coverage, including knowledge of payment amounts and yearly deductibles.

FINANCIAL RESPONSIBILITY
The client (or referring parent in the case of minors) is considered responsible for payment of professional fees. It is the client's responsibility to know if services are covered and the amount of their deductible and/or co-payment. When we are asked to bill a third-party such as an insurance company, and that third-party fails to make timely payments, payment is expected from the client or referring parent that signed the consent for services. The client will be responsible for fees for claims that are denied (e.g., due to exceeding the number of available sessions, if new coverage has not begun or if insurance has changed, filing past the insurance carrier's time limit, etc.)

BILLING
While payment at the time of service is expected, we bill monthly for outstanding balances and to keep you up-to-date regarding the status of your account. Refunds will also be mailed on a monthly basis.

PAST DUE ACCOUNTS
We send out several letters to clients with past due accounts in an effort to provide an opportunity to pay in full or make payment arrangements. If a client has not made good faith efforts to pay their bill, the overdue account may be assigned to a collections agency and all collection costs associated with the debt will be the client's responsibility. We also reserve the right to assign the account to small claims court, depending on the total balance due.

I have read, understand and agree with the provisions of this policy.

Consumer's Signature: _____ **Date:** _____

Legal Guardian's Signature: _____ **Date:** _____

GYG Staff's Signature: _____ **Date:** _____

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CANCELLATION, NO SHOW AND LATE ARRIVAL POLICY

Grow Yourself Great Counseling and Consulting, PLLC would like to make sure that you access high-quality treatment services when you need it. To ensure we provide everyone with quality services, please be aware of the following appointment policy:

Scheduled Appointments: If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know. This allows us enough time to offer your appointment to another client. Failure to provide at least 24 hours' notice counts as a missed appointment. If 24 hour notice is not received, a fee of $25.00 will be charged to your account (excludes Medicaid and Health Choice Insurances). This fee is not covered by insurance and is therefore the sole responsibility of the Client.

Missed Appointments: Missed appointments will be documented in your record with us. If you miss more than four scheduled appointments you will be informed that Grow Yourself Great Counseling and Consulting, PLLC will be unable to provide additional services and you will be discharged from the practice.

Late Arrivals: If you arrive more than 15 minutes late for your scheduled appointment you will be given one of the following options:

- You may reschedule the appointment or
- Wait for an available same-day opening in the schedule

Appointment Reminders: Please note that appointment reminders are provided as a courtesy of GYG. In the event that you do not receive a reminder, making your scheduled appointments remains your responsibility. We encourage you not to rely on GYG reminders as your only means of remembering your appointments.

I understand and agree to abide by this cancellation, No Show, and Late Arrival Policy.

_____
Client Name (Print)

_____ _____
Client Name (Signature) Date

If the consumer has a legal guardian:

_____
Parent/Legal Guardian (Print)

_____ _____
Parent/Legal Guardian (Signature) Date

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AUTHORIZATION TO KEEP CREDIT CARD ON FILE

Cardholder Name: _____

Card Type: ☐ Master Card ☐ Discover Card ☐ American Express

☐ Visa Card ☐ Other Card Type: _____

Card Number: _____

Security Code: _____ Expiration Date: _____

Billing Address for Card: _____

_____

I, the undersigned am an authorized signer of the credit card detailed above. I have previously signed and agreed to the terms of the Cancellation, No Show and Late Arrival Policy as well as the Fees and Insurance Policy. I authorize Grow Yourself Great Counseling and Consulting, PLLC to make a copy and use the credit card information above to pay for any no call, no show fees, late cancellation fees, copay amounts, co-insurance balances or fees incurred for services. I will be provided a paper or electronic copy of my receipt after each payment.

_____
Cardholder Name

_____ _____
Cardholder Signature Date

I wish to also receive receipts by (check all that apply) :

☐ Email: _____

☐ Fax: _____

☐ Mobile: _____

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RELEASE OF INFORMATION

Authorization for Use and Disclosure of Protected Health Information

I,_____(Consumer / Guardian), authorize GYG, PLLC to disclose private health information to _____Agency or Person to whom the requested use or disclosure will be made effective on the date of my signature.)

Reason for information to be released: *continuity of care*_____

_____

I consent to the release of information or records created by or disclosed to GYG, PLLC pertaining to:

_____ Person Centered Plans / Treatment plans
_____ Crisis Plan
_____ Service Notes / Reports/ Updates
_____ School Records
_____ Psychological Reports
_____ Immunization/Medical Reports
_____ Other (Please be _____

_____ Assessments
_____ Admission/Intake Information
_____ Discharge Information
_____ Guardianship Paperwork
_____ Written & verbal communications pertinent to Tr

Please initial the lines below

_____ I understand that the information disclosed may have been created by GYG, PLLC or released to GYG, PLLC by other agencies (i.e. re-release)

_____ I understand this is a full release and that information disclosed regarding my treatment may include (if applicable) information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) in compliance with 42 CFR Part 2 and will be confidential and disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section..

_____ I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that GYG, PLLC cannot deny or refuse to provide services.

_____ I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing.

If not revoked earlier, this authorization expires on: _____ (date) **not to exceed one year of signature**.

Consumer's Signature: _____ **Date:** _____

Legal Guardian's Signature: _____ **Date:** _____

GYG Staff's Signature: _____ **Date:** _____

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MEDICAL RELEASE OF INFORMATION

Authorization for Use and Disclosure of Protected Health Information

I, _____ (Consumer / Guardian), authorize GYG, PLLC to disclose private health information to:

Practice Name: _____ **Physician Name:** _____

Address: _____ **Phone:** _____

(Agency or Person to whom the requested use or disclosure will be made effective on the date of my signature.)

Reason for information to be released: *continuity of care* _____

I consent to the release of information or records created by or disclosed to GYG, PLLC pertaining to:

_____ Person Centered Plans / Treatment plans
_____ Crisis Plan
_____ Service Notes / Reports/ Updates
_____ School Records
_____ Psychological Reports
_____ Immunization/Medical Reports
_____ Other (Please be sp_____

_____ Assessments
_____ Admission/Intake Information
_____ Discharge Information
_____ Guardianship Paperwork
_____ Written & verbal communications pertinent to Treatr

Please initial the lines below

_____ I understand that the information disclosed may have been created by GYG, PLLC or released to GYG, PLLC by other agencies (i.e. re-release)

_____ I understand this is a full release and that information disclosed regarding my treatment may include (if applicable) information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) in compliance with 42 CFR Part 2 and will be confidential and disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section..

_____ I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that GYG, PLLC cannot deny or refuse to provide services.

_____ I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing.

If not revoked earlier, this authorization expires on: _____ (date) **not to exceed one year of signature**.

Consumer's Signature: _____ **Date:** _____

Legal Guardian's Signature: _____ **Date:** _____

GYG Staff's Signature: _____ **Date:** _____