REGISTRATION FORM

Today's date:						
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former/Maiden name):	Birth date: / /	Age:	Sex: ❑ M	❑ F
Race ❑ Black/African American ❑ Caucasion ❑ Hispanic/Mexican ❑Other:						
Street address:			Home phone no.: ( ) Cellphone no.: ( )			
P.O. box:	City:		State:		ZIP Code:	
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Is this patient covered by insurance? ❑ Yes ❑ No						
Please indicate **primary insurance** ❑ Medicaid ❑ Medicare ❑ HealthChoice ❑ BCBS of NC ❑ Tricare						
❑ Other namely:						
Subscriber's name:		Birth date:				
Subscriber's Policy no.:		**Group no**				
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
Name of **secondary insurance** (if applicable):	Subscriber's name:		**Policy no.:**	**Group no.:**		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:		Work phone no.:	
			( )		( )	

PRIMARY CARE INFORMATION Please complete each item on the form. If an item is not applicable, please indicate that but do not leave blank spaces on your form.	
Primary Doctor:	Phone #: ( )
Address:	Allergies:
PHARMACY INFORMATION Please complete each item on the form. If an item is not applicable, please indicate that but do not leave blank spaces on your form.	
Pharmacy:	Phone #:

For <practice use>
Client Name: …… DOB: …… MR#: ……

Statement of confidentiality and consent for treatment

I understand that as a patient of TriCare Counseling & Consulting I may be eligible to receive all services that are offered. The goal of the assessment process is to determine the best course of treatment for me. I understand that all information shared with the clinicians at TriCare Counseling & Consulting is confidential and no information will be released without my consent. During the course of treatment at TriCare Counseling & Consulting, it may be necessary for my provider to communicate with other providers at TriCare Counseling & Consulting. While written authorization will not be requested, prior to any discussions with TriCare Counseling & Consulting provider, I understand that in all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

Telephsychiatry services are offered by a physician at TCC. I understand that “Telepsychiatry” means I will be seeing the doctor on a display screen in this office and the doctor will see me on his device display. I understand that I will be able to talk back and forth, just the same as if the doctor were actually sitting in the room with me. This system has been put in place to help me access care in a timely fashion. I understand that I do not have to participate in telepsychiatry treatment and that I will have to wait and schedule a visit with another provider or agency, perhaps in a distant community. I understand that the doctor will take notes for the medical record and will make treatment recommendations the same as if I saw him in person. I understand that the medical information is confidential information. I understand my privacy will be protected and no other screen except the one in the room with my doctor will have my picture on it. No video recording of the visit with my doctor will be made and no other individuals wither here or in my doctor’s office will see or hear anything I have said to the doctor without my permission or as allowed by NC General Statutes.

If I have any questions regarding this consent form or about the services offered TriCare Counseling & Consulting, I may discuss them with my provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by TriCare Counseling & Consulting. I understand that I may stop treatment at any time.

FIRST AID I (we) authorize TriCare Counseling & Consulting to obtain emergency medical, Dental, or mental health care. Including transportation, for this client, until I (we) can be reached to authorize further care. I (we) agree to assume all cost for such transportation until medical help arrives, in an emergency, I (we) want TriCare Counseling & Consulting to contact the person indicated on my personal information form.

The above information is true to the best of my knowledge. I consent to treatment and I authorize my insurance benefits be paid directly to the provider I understand that I am financially responsible for any balance that is not covered by my insurance company. Where required, I also request payment of government benefits to the party who accepts assignment. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

x _____ x _____

Patient/Parent/Guardian Signature *Date*

Authorization of Disclosure/Release of Information

☐ I, _____, hereby authorize **not** to share, exchange, use, and disclose the specified protected information in my or my child's record with anyone.

☐ I, _____, hereby authorize **TriCare Counseling & Consulting, Inc**. to share, exchange, use, and disclose the specified protected information in my or my child's record with listed person or organization

_____ _____

Purpose of the disclosure:

____Assist with treatment ____Referral _____ Other: _____

This information shall include only the following (please check all that appy):

____I authorize the release of my mental health records including diagnosis, treatment plan, and medication management records
____I authorize the release of communicable diseases, HIV or Aids
____I authorize the release of Alcohol/drug abuse treatment

___Check here if minor client seeks release of information for treatment of venereal disease, pregnancy, abuse of controlled substance or alcohol, or emotional disturbances. (Client may authorize release)

Effective period (please check the applicable option)

___This authorization for release of information covers the period of one year.
or
___This authorization for release of information begins today and ends on _____.
I may request a copy of this signed authorization.

My right to confidentiality has been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality, I understand that I may revoke this consent at any time, either verbally or in writing, except where releases of information based upon this consent have already occurred.

I understand that the above recipient party, without my further consent, may not release this information. That TriCare Counseling & Consulting, Inc. is required by HIPPA privacy law to protect my health information. However once TriCare Counseling & Consulting, Inc. discloses information, I understand the TriCare Counseling & Consulting, Inc. has no control over my privacy with regard to the recipient of the information.

I further understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. A legible photocopy of this document shall be considered as valid as the original.

Client Signature: _____ Date: _____

Guardian: _____/Relationship to client: _____ Date: _____

Client must sign whether a child or adult; information protected by Federal Regulations 42 CFR Part II.

Notice of Policies and Practices (NPP) to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- **"*PHI*"** refers to information in your health record that could identify you.
- ***"Treatment, Payment and Health Care Operations"***
  - ***Treatment*** is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - ***Payment*** is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - ***Health Care Operations*** are activities that relate to the performance and operation of our practice. Examples of health care operations include: quality assessment and improvement activities, business-related matters such as audits and administrative services, and care coordination.
- **"*Use*"** applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **"*Disclosure*"** applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An ***"authorization"*** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. ***"Psychotherapy notes"*** are notes your therapist has made about your conversation during a private, group, joint, or family counseling session, which has been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that **(1)** We have relied on that authorization; or **(2)** if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

The following include some of the circumstances we may use or disclose PHI without your consent or authorization. (According to NCGS Chapter 122C article 3):

1. We may disclose the fact of admission or discharge of a client to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.
2. An internal client advocate shall be granted, without the consent of the client or his legally responsible person, access to routine reports and other confidential information necessary to fulfill his monitoring and advocacy functions.
3. **Abuse reports and court proceedings**: We shall disclose confidential information if a court of competent jurisdiction issues an order compelling disclosure. Upon a determination by the facility director or his designee that disclosure is in the best interests of the client, a facility may disclose confidential information for purposes of filing a petition for involuntary commitment of a client pursuant to Article 5 of this Chapter or NC General Statutes - Chapter 122C Article 3 3 for purposes of filing a petition for the adjudication of incompetency of the client and the appointment of a guardian or an interim guardian under Chapter 35A of the General Statutes. If an individual is a defendant in a criminal case and a mental examination of the defendant has been ordered by the court as provided in G.S. 15A-1002, the facility shall send the results or the report of the mental examination to the clerk of court, to the district attorney or prosecuting officer, and to the attorney of record for the defendant as provided in G.S. 15A- 1002(d). The report shall contain a treatment recommendation, if any, and an opinion as to whether there is a likelihood that the defendant will gain the capacity to proceed. Certified copies of written results of examinations by physicians and records in the cases of clients voluntarily admitted or involuntarily committed and facing district court hearings and rehearings pursuant to Article 5 of this Chapter shall be furnished by the facility to the client's counsel, the attorney representing the State's interest, and the court. The confidentiality of client information shall be preserved in all matters except those pertaining to the necessity for admission or continued stay in the facility or commitment under review. We may disclose confidential information to staff attorneys of the Attorney General's office whenever the information is necessary to the performance of the statutory responsibilities of the Attorney General's office
4. **Care and treatment**: Any facility may share confidential information regarding any client of that facility with any other facility when necessary to coordinate appropriate and effective care, treatment or habilitation of the client. Any facility may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with a facility when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment or habilitation of the client.
   - As used in this section, "facility" includes an LME and "Secretary" includes the Community Care of North Carolina Program, or other primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services.
   - We may share confidential information when necessary to conduct payment activities relating to an individual served by the facility.
   - Whenever there is reason to believe that a client is eligible or need **to** maintain eligibility for benefits through a Department program, any State or area facility may share confidential information.
   - An area authority or county program may share confidential information regarding any client with any area facility, and any area facility may share confidential information regarding any client of that facility with the area authority or county program, when the area authority or county program determines the disclosure is necessary to develop, manage, monitor, or evaluate the area authority's or county program's network of qualified providers. The purposes or activities for which confidential Information may be disclosed include, but are not limited to, quality assessment and improvement activities, provider accreditation and staff credentialing, developing contracts and negotiating rates, investigating and responding to

client grievances and complaints, evaluating practitioner and provider performance, auditing functions, on-site monitoring, conducting consumer satisfaction studies, and collecting and analyzing performance data.

- Any area facility may share confidential information with any other area facility regarding an applicant when necessary to determine whether the applicant is eligible for area facility services. A facility may share confidential information with one or more HIPAA covered entities or business associates for the same purposes.
- A facility, physician, or other individual responsible for evaluation, management, supervision, or treatment of respondents examined or committed for outpatient treatment under the provisions of Article 5 of this Chapter may request, receive, and disclose confidential information to the extent necessary to enable them to fulfill their responsibilities.
- A facility may furnish confidential information in its possession to the Division of Adult Correction of the Department of Public Safety when requested by that department regarding any client of that facility when the inmate has been determined by the Division of Adult Correction of the Department of Public Safety to be in need of treatment for mental illness, developmental disabilities, or substance abuse.
- The Division of Adult Correction of the Department of Public Safety may furnish to a facility confidential information in its possession about treatment for mental illness, developmental disabilities, or substance abuse that the Division of Adult Correction of the Department of Public Safety has provided to any present or former inmate if the inmate is presently seeking treatment from the requesting facility or if the inmate has been involuntarily committed to the requesting facility for inpatient or outpatient treatment. Under the circumstances described in this subsection, the consent of the client or inmate shall not be required in order for this information to be furnished and the information shall be furnished despite objection by the client or inmate.
- A responsible professional may disclose confidential information when in his opinion there is an imminent danger to the health or safety of the client or another individual or there is a likelihood of the commission of a felony or violent misdemeanor.
- A responsible professional may exchange confidential information with a physician or other health care provider who is providing emergency medical services to a client.
- A responsible professional may disclose an advance instruction for mental health treatment or confidential information from an advance instruction to a physician, psychologist, or other qualified professional when the responsible professional determines that disclosure is necessary to give effect to or provide treatment in accordance with the advance instruction.
- Whenever there is reason to believe that the client is eligible for financial benefits through a governmental agency we may share confidential information.
- We may disclose confidential information for the purpose of collecting payment due the facility for the cost of (a) Within a facility, employees, students, consultants or volunteers involved in the care, treatment, or habilitation of a client may exchange confidential information as needed for (b) Upon specific request, a responsible professional may release confidential information to a physician or psychologist who referred the client to the facility.
- Upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client or his legally responsible person, the responsible professional shall provide the next of kin, or family member, or the designee, notification of the client's admission to the facility, transfer to another facility, decision to leave the facility against medical advice, discharge from the facility, and referrals and appointment information for treatment after discharge, after notification to the client that this information has been requested.
- Whenever there is reason to believe that the client is eligible for educational services through a governmental agency, a facility shall disclose client identifying information to the Department of Public Instruction. Disclosure is limited to that information necessary to establish, coordinate, or maintain educational services. The Department of Public Instruction may further disclose client identifying information to a local school administrative unit as necessary.

5. **Research & Planning**: A facility may disclose confidential information to persons responsible for conducting general research or clinical, financial, or administrative audits if there is a justifiable documented need for this information.
6. **Any suspected abuse, neglect, exploitation, and communicable diseases:** If you provide us with any information that leads us to suspect any abuse, neglect, exploitation, and communicable diseases, we must report such information to the county Department of Social Services and or Department of Health and or Department of any applicable Federal, State, and or local agency charged with Health and Safety.
7. **Child Abuse:** If you give us information that leads us to suspect child abuse, neglect, or death due to maltreatment, we must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, we must do so.
8. **Adult and Domestic Abuse:** If information you give us gives us reasonable cause to believe that a disabled adult is in need of protective services, we must report this to the Director of Social Services.
9. **Health Oversight:** The North Carolina Psychology Board has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.
10. **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without your written a authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
11. **Serious Threat to Health or Safety:** We may disclose your confidential information to protect you or others from a serious threat of harm by you.
12. **Worker's Compensation:** If you file a workers' compensation claim, we are required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.

CLIENT'S RIGHTS AND AGENCY RULES

As a client of TriCare Counseling & Consulting, Inc you have the following rights

• To consent to or to refuse treatment. • To receive treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability. • To be treated with respect and dignity • To have your privacy protected • To help develop a plan of care with services to meet your needs • To participate in decisions regarding your mental health care • To receive services in a barrier-free location (accessible) • To request information about names, location, phones, and languages for local agencies • To receive the amount and duration of services you need • To request information about the structure and operation of the Client Right Committee • To services within two hours for emergent care and 24 hours for urgent care • To be free from use of seclusion or restraints • To receive age and culturally appropriate services • To be provided a certified interpreter and translated material at no cost to you	• To understand available treatment options and alternatives • To refuse any proposed treatment • To receive care that does not discriminate against you (e.g. age, race, type of illness) • To be free of any sexual exploitation or harassment • To receive an explanation of all medications prescribed and possible side effects when applicable • To make an advance directive that states your choices and preferences for mental health care • To receive quality services which are medically necessary • To have a second opinion from a mental health professional • To file a grievance with your agency or Office of Civil Rights • To choose a mental health care provider or choose one for your child who is under 21 years of age • To file a request for an administrative (fair) hearing • To request and receive a copy of your medical records and ask for changes. You will be told the cost. • To be free from retaliation • To request and receive policies and procedures of TCC as they pertain to your rights
You have the right to contact the Disability Rights North Carolina (formerly the Governor's Advocacy Council for Persons of Disabilities). 3724 National Drive, Suite 100, Raleigh, NC 27612 |Toll-Free: 877-235-4210 | Phone: 919-856-2195 | Fax: 919-856-2244	
If you feel your rights are not met, you may also contact the Office of Civil Rights for more information at Office for Civil Rights Department of Health and Human Services. Attn: Patient Safety Act. 200 Independence Ave., SW, Rm. 509F. Washington, DC 20201 | (202) 619-0403 TDD 1-800-537-7697 Or go to www.hhs.gov/ocr	

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Agency Rules

- We require that you identify yourself with proper identification (i.e. Drivers license, Passport, Social Security Card, etc.) and provide us with proof of insurance.
- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- Speak with your therapist about obtaining a copy of your treatment plan.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post such changes in the office and will provide paper copies of changes upon request. You may be required to review and acknowledge such changes in policy in writing.

Behavioral Health Appointment Procedures: **We provide 24-hour access for behavioral health emergency services.**
Emergent/Crisis: Call 910-249-4219 to speak with someone. We will meet with you face-to-face within 2 hours. Please note that staff may call 911 for your safety if necessary. **Urgent appointment**: Call 910-249-4219 to schedule an appointment within 48 hours. Do let the staff know you need an urgent appointment.
Routine appointment: Call 910-249-4219 to schedule a routine appointment. We will schedule your appointment within 14 days.

Office Wait Time: Scheduled appointment: You will be seen within 15 minutes of your appointment time and no later than 60 minutes. If you have not been seen within 15 minutes of your arrival time, please see the receptionist to get an update on your appointment. If you have not been seen within 60 minutes, you have the right to reschedule your appointment the following available day.
Walk-ins: As a walk-in you will be provided a screening to determine your level of need (Emergent, Urgent, or Routine). Once the need is determined, we will manage your case according to the level of need.

Other rules: We ask that reschedules and cancellations be made as far in advance as possible, but within at least twenty-four (24) hours. We reserve the right to charge $30 for missed appointments or same day cancellations/reschedules. Frequent no-shows/cancellations may result is discharge.
Minors must be accompanied by their legal guardian(s) to receive services. Legal guardians must give consent for services in writing.
Weapons are not permitted on the property. No pets are allowed. No smoking is allowed. We ask that you refrain from using your telephone during sessions.
Co-payments/Payments for services are due prior to services are rendered. You are responsible for any balances your insurance payer did not cover. Unpaid balances must be paid before the next appointment.

COMPLAINTS & COMPLIMENTS

- If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, please contact the Executive Director at **(910)249-4219** or send a written complaint to TriCare Counseling & Consulting, Inc. to the attention of the Executive Director at **731 Tilghman Dr. Dunn, NC 28334.** Your complaint will be resolved within 30 days.
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

EFFECTIVE DATE, RESTRICTIONS AND CHANGES TO PRIVACY POLICY
This notice went into effect initially on April 18, 2011, **updated 09/25/2017**. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. Revised notices are posted in the office waiting room or on our website: www.tricarecounseling.com.

For <practice use>
Client Name: …… DOB: …… MR#: ……

I have been notified/educated on my individual rights and agency rules.

I have been given a copy of TriCare Counseling & Consulting, Inc.'s Notice of Privacy Practices and I agree to agency rules and consent to the uses and disclosures of my health information as outlined in the notice.

_____ _____

Signature of Client & date

_____ _____

Signature of Parent/Guardian & date

FOR <PRACTICE> USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it: