CONFIDENTIAL CLIENT INFORMATION

Welcome to the Chrysalis Center. Please answer all the questions as honestly as you can. You may leave any questions blank that you don't feel comfortable answering or that do not apply to you. Any information you provide is strictly confidential.

Demographic Information:

Name ____ SSN _____________ Date ___________________

Mailing Address: ____

____

City: _________________________________ State ______________ Zip Code ________________

Email Address: ____

Home Phone: ___________________ Work Phone ___________________ Cell Phone: ____________________

What is the best way to contact you? ___________________ Is it okay to leave a message? Yes No

___________________	______	______	___________________	___________________
Date of Birth	Age	Sex	Ethnic Group	Religious Preference

Relationship Status: Single___ Cohabitating___ Married___ Separated____ Divorced____ Widowed___

Emergency Contact: ____ Telephone: (____) ________________

Parent/Guardian (if relevant): Name: ____

Address: ____ Telephone: (____) ________________

Housing Status: With parents ___ With roommate ___ Student Housing ___

Live Alone ___ With partner/spouse ___

Referral Information: How did you found out about nutrition services?

____

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? ____

What is your job title? ____

For Office Use Only: Date of Last Information Update and Initials of Staff Member Completing

Education Information:

Highest Level of Education Completed:

Grade School ____ High School ___ College ___ Graduate School ____

Are you currently a student? Yes No

If yes, where? _________________________ Year _____________ Major _________________________

<u>Health Information</u>:

Nutrition Counseling History:
Have you ever met with a nutritionist before? Yes No
If Yes:
Name of nutritionist(s): ____

Presenting problem:____

When and why did you stop? ____

Current Medications, Supplements & Vitamins	Daily Dose	Start Date	Name of Prescriber

Please list any chronic illnesses, injuries, physical conditions or disabilities:_________________________

____

____

____

Allergies/Adverse Reactions to Treatment:____

____

Primary Care Physician Name: ____

Address: ____ Telephone: (____) _________________________

____

Check below if you or any family member(s) are currently experiencing or have experienced any of the following?

	Self	Family
Anorexia Nervosa	_____	_____
Bulimia Nervosa	_____	_____
Binge Eating	_____	_____
Compulsive Overeating	_____	_____
Obesity	_____	_____
Workaholism	_____	_____
Anxiety or Panic Disorder	_____	_____
Depression	_____	_____
Mood Swings	_____	_____
Bipolar Disorder	_____	_____
Emotional Problems	_____	_____
Nervous Breakdown	_____	_____
Suicide – attempt or committed	_____	_____
Alcohol Abuse	_____	_____
Drug Abuse	_____	_____
Laxative/Diuretic Use	_____	_____
Stealing / Shoplifting	_____	_____

	Self	Family
Rape	_____	_____
Sexual Abuse	_____	_____
Emotional Abuse	_____	_____
Physical Abuse	_____	_____
Psychiatric Hospitalization	_____	_____
Anemia	_____	_____
Hypoglycemia	_____	_____
Diabetes	_____	_____
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
Heart Disease	_____	_____
Irritable Bowel	_____	_____
Diverticulitis	_____	_____
Intestinal Problems	_____	_____
Cancer	_____	_____
Chronic Health Problems	_____	_____

Other (please explain) ____

Food Allergies: ____

Food Intolerances: ____

Foods Avoided: ____

Weight and Exercise History

Height:__________ Current weight: ___________pounds What is your desired weight?__________

How often do you weigh yourself?_________________

What was your highest weight?__________ Age_____ What was your lowest weight?__________ Age_____

Briefly describe any diets you have tried and how long you followed them:

____

____

____

Briefly describe your exercise habits (current and past):

____

____

____

Please list any nutrition/eating pattern/exercise goals that you hope to achieve as a result of nutritional counseling. Also please include any other information when you feel would be helpful.

____

____

____

____

____

Chrysalis
Center for Counseling
and Eating Disorder Treatment

RIGHTS & CONSENT TO TREATMENT

- You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- You have the right to be treated in accordance with professional and ethical standards of conduct.
- You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Clinical records will be maintained in a secure, locked environment. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order.
- You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- I understand that sessions run for 45-50 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- I understand that there is no guarantee that any particular outcome will result from treatment.
- I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians, Kelly Broadwater, LPA, LPC, Kim Longbottom, LCSW, LCAS, Annmarie Miller, LCSW, Ashley Swinson, LCSW, and Kendra Wilson, LCSW and the nutritionists, Chaundra Klein, RD, LDN and Terri Mozingo, RD, LDN actively collaborate and consult about mutual cases, as well as share clinical notes.
- I understand that my therapist may consult and share clinical information with their supervisor and/or clinical board in order to provide legal and ethical treatment. They may also do so to meet the requirements set forth for their licensure or certification.

I have read and understood this document and will address any concerns or questions with my therapist and/or the office manager.

Client/Representative Signature ______________________________________ **Date** _______________

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature ____ **Date** _______________

Revised 07.14.2011

Office Procedures and Financial Agreement

Please read, initial, and sign below. You may request a copy for your records.

Chrysalis is a business facility where a number of mental health professionals practice. Your contract for services is with our facility and applies to any and all providers you may see here.

APPOINTMENTS:

All office visits are by appointment and may be scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. The usual length of an appointment is 45-50 minutes. If you arrive more than 15 minutes late, you may be asked to reschedule your appointment, which will result in a *late cancellation* charge.

Payment: Payment is required at the time services are rendered, whether you are a self-pay client or have insurance benefits. Please note: if you are unable to provide payment at the time of service, you will not be seen and your appointment will be considered a *late cancellation*. You will be charged for the appointment time. Acceptable methods of payment include cash, check, and credit card. *The fee for returned checks is $35. If a second check is returned, you will be asked to arrange another method of payment.*

Late cancellations/No shows: For a missed or late cancelled clinical or nutritional appointment, you will be charged the *self-pay* rate for the appointment (unless otherwise specified by your insurance carrier). Please note: both clinical and nutritional appointments must be cancelled by 9:00am the business day before. Please be advised that reminder calls are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

INSURANCE:

Insurance co-payments are due at the time of service. If your insurance deductible has not yet been met, you will be billed the full charge for services. As a courtesy to you, we will bill rendered services to your insurance carrier. We cannot guarantee insurance coverage, nor that the information provided by your carrier is accurate. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. *It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility.*

Please note: treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers, may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

Medicaid/Medicare: Co-payments are due at the time of service. You are also required to present your Medicaid or Medicare Card at each visit. Failure to present your card may result in your not receiving services. If your Medicaid or Medicare coverage has lapsed or terminated, please be advised that you will be responsible for payment in full for services rendered during that time.

OUTSTANDING BALANCE:

You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued.

If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from

treatment, and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with the Office Manager or Accounts Receivable Manager.

Late Fees: A late fee of $25 will be charged to accounts that are not paid within 30 days of receipt of the first bill. If payment is not received by the third billing cycle, your delinquent account may be referred to collections and you will be responsible for all associated collections and fees.

ADDITIONAL SERVICES

In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring for psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment.

Phone Calls: Typically there is no charge for phone calls. However, phone calls that are extended and/or that constitute therapy may be billed at our self-pay rate.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do not reimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Case Management Fee: Extensive services that involve clinical coordination and continuity of care may constitute an additional fee that is separate of therapeutic services.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

______ I have read, understand, and agree to the above policies.

______ I have discussed these policies and addressed concerns and questions with the Office Manager or AR Manager.

______ I have been offered a copy of these policies to take with me if I desire.

______ I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.

______ I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

______________________________ ______________

Signature of Client Date

______________________________ ______________

Signature of parent or Legal Guardian Date

______________________________ ______________

Signature of Office or AR Manager Date

**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): ______________________________

Address: ______________________________

Telephone: ______________________________

Birth Date: ______________________________

Social Security Number: ______________________________

Relationship to Policy Holder:______________________________

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): ______________________________

Policy Holder's Address: ______________________________

____

Policy Holder's Telephone: ______________________________

Policy Holder's Birth Date: ______________________________

Policy Holder's Social Security Number: ______________________________

Employer's Name: ______________________________

Insurance Plan Name: ______________________________

Subscriber Number or Member ID Number: ______________________________

Group Number: ______________________________

* Please see reverse side for secondary insurance information and consenting signature.

<u>Secondary Insurance Information</u> (If applicable):

Policy Holder’s Full Name (Including Middle): ______________________________

Policy Holder’s Address: ______________________________

____

Policy Holder’s Telephone: ______________________________

Policy Holder’s Birth Date: ______________________________

Policy Holder’s Social Security Number: ______________________________

Employer’s Name: ______________________________

Insurance Plan Name: ______________________________

Subscriber Number or Member ID Number: ______________________________

Group Number: ______________________________

I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

______________________________ ______________________________

Name of Client (printed) Date

____

Signature

ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES & CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, ________________________ and Chrysalis Center. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name(s) here
____.
When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form you are agreeing to let us use your information and send it to others. Please read the Notice of Privacy Practices dated 05.25.2010 before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.chrysaliscenter-nc.com, or by calling us at 910-790-9500. If you have any questions regarding the Notice or your privacy rights, you can also contact Kendra Wilson, LCSW, Privacy Officer, at kendra@chrysaliscenter-nc.com or at the address listed below.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to our Privacy Officer at Chrysalis Center about these concerns. (Although we will try to respect your wishes, we are not required to agree to these limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter to the Privacy Officer). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Chrysalis Center's Notice of Privacy Practices. My signature indicates that I have reviewed this notice and understand its content.

Signature: ____ Date: ______________

Printed Name: ________________________________ Date of Birth: ______________

Relationship to Client (if guardian or representative):______________________________

** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).*

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

□ ***Client Refuses to Acknowledge Receipt***:
Signature of authorized representative of this office or practice: ______________________________