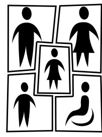

Psychological Mobile Services[PA]

Clayton, NC ~ P: (919) 243 – 0454
F: (919) 243 – 0923
Wilson, NC ~ P: (252) 291 – 0735
F: (252) 291 – 2890
www.PsychologicalMobile.com

New or *Updated* Member Paperwork ☐ Clayton ☐ Wilson

Name (legal name of person being seen): ______________________________

Date of Birth: ____________ **Age:** ____________ **Today's Date:** ____________

Client Demographics:

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ Asian ☐ Black or African American ☐ White or Caucasian /Euro American
☐ Native American ☐ Mid Eastern ☐ Latino ☐ Native Hawaiian/Pacific Islander
☐ Other: ______________________________

Veteran: ☐ Yes ☐ No

Address: ______________________________

City / State / Zip: ______________________________

Phone(s): ______________________________

Legal guardian(s): ☐ Self ☐ Other (**Name**): ______________________________

NOTICE ***Guardians MUST submit legal proof of guardianship paperwork***

Referral Source: ______________________________

Doctor / NPI*: ______________________________

***Note:** *Medicaid & Medicare members require a physician or psychiatrist to be listed*

Please Provide *All Insurance Cards* or Provide Your Insurance Information Below:

☐ **SEE ATTACHED COPY OF CARD(S)**

Primary Insurance: ______________________________

Secondary Insurance: ______________________________

IN CASE OF EMERGENCY CONTACT:

Name: ____________________ Relationship: ______________ #: ______________

Psychiatric Medications (print or provide a list): ______________________________

____

____

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Consent for Treatment

I authorize the evaluation and/or treatments of the patient identified above and agree to pay all charges for the evaluation and/or treatment provided. I hereby authorize the release of information related to the services provided to my insurance and/or managed care company and authorize payment by the insurance and/or managed care company directly to Psychological Mobile Services, P.A. A copy of this authorization can be used in place of the original.

Important Policy information:

1) Anyone that cancels or reschedules less than 24hours before the scheduled appointment time or anyone that that does not show for a scheduled appointment will be charged a $30 missed appointment fee. The member will not be able to schedule another appointment until this fee is paid in full. **Medicaid members will not be charged**, however, they will only be able to schedule a future appointment in person.

2) At Psychological Mobile Services we provide many Psychological Evaluations. After all Testing is completed a Psychological Report is written, the parent or guardian may schedule an in-office "Review" which involves a consultation. Depending on the age and issues of concern for the client/member that was tested they may or may not need to be present. In addition, we now also offer a phone consultation. At this time, phone consults are available for self-pay only and must be pre-paid ($50) before scheduled. Phone consults are typically up to 30minutes and insurance companies do not pay for phone consultations. Testing psychological report rush orders (7 day turn around) are also available at a pre-paid fee ($50) and this is not covered by insurance.

Notice of rights, privacy, & policies receipt and acknowledgment of notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Psychological Mobile Services, PA's Notice of Rights, Privacy and Policies. I understand that if I have any questions regarding the Notice of my rights and/or privacy I can contact Psychological Mobile Services, PA.

Payment for services

I hereby acknowledge that Payment is due at the time of service for any amount known to be not covered, or not paid by your insurance plan. This includes all coinsurance and deductible.

By signing below you agree to all terms and conditions defined above regarding the following:
1) Treatment consent **2)** Emergency consent and **3)** Disclosure information **4)** Treatment Services and **5)** Notice & acknowledgment of rights, privacy, and policies **5)** Professional Disclosure Statement.

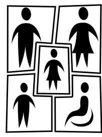
X

Member / Guardian Sign ***Date***

***Witness:* X**

Witness to completed, reviewed, and signed paperwork ***Date***

ADD STICKER (Member ID / Information)



Release / Exchange of Information
www.PsychologicalMobile.com

Authorization To Disclose Health Information

Name: ______________________________ Date of Birth: ______________

Information Released To:

☐ MCO
☐ Physician / Psychiatrist
☐ School (if applicable)
☐ Other(s):

Information Released From:

Agency:	***Psychological Mobile Services, P.A.***
Address:	2401-K Wooten Blvd. Wilson, NC. 27893
	105 S. Ellington St. Clayton, NC. 27520
Phone:	Wilson: 252-291-0735 ~ Clayton: 919-243-0454
Fax:	Wilson: 252-291-2890 ~ Clayton: 919-243-0923

Reciprocal Authorization for Release of Information (Check if applicable)

☐ I authorize Psychological Mobile Services, P.A. to have continuous dialogue between the personnel of Psychological Mobile Services, P.A. and the individual or group identified above. The individual or group identified above is also hereby authorized to release or share information with Psychological Mobile Services, P.A.

Description of Information to be released (if not checked, then assumed refused)

Reason for Disclosure:

☐ Continuity of care / treatment coordination
☐ Personal records
☐ Provider transfer
☐ School request
☐ Other: ______________________________

☐ Therapy records
☐ Protected Health Information (PHI)
☐ Evaluations / treatment summaries
☐ HIV/AIDS information
☐ Drug / Alcohol information
☐ Other: ____________________

- I hereby authorize the release and/or exchange of the above identifying information from my records. I hereby release Psychological Mobile Services, P.A. from all legal responsibility or liability that may arise from this authorization. I understand that I have the right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time, except to the extent that Psychological Mobile Services, P.A. has taken reliance upon it. I also understand that such revocation must be in writing and received my provider to be effective.
- I understand that I may refuse to sign this release and that Psychological Mobile Services, P.A. may not condition treatment/services on me signing this form. I understand that information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule. Note: North Carolina law prohibits re-disclosure of any confidential information involving mental health or substance abuse treatment, without the client's permission.
- I understand that the information to be released may include information regarding HIV/AIDS (10A NCAC 26B.0202; GS 130A-143) and substance abuse information per the confidentiality and disclosure requirements of 42 CFR Part 2. The information shall be released only in accordance with NCGS 130A-143.
- Please be informed that confidential information may not be released without written consent except in emergency or as provided for in General Statutes 122C-52 through 122C-56, and that release/disclosure may occur without consent in the case of required emergency treatment, request from the funding source, or an audit.
- Please sign, indicating you have are aware and understand the terms regarding confidentiality, the provision of services is not contingent upon such consent and of the need for such release, the client or legally responsible person shall give consent voluntarily, and that confidential information may not be disclosed without written consent when federal statutes prohibit that release.

This authorization shall remain **valid for one year** from the date of signature or until: ____________________

X ____ ______________

Member (or Guardian Signature & list relationship) ***Date***

☐ *This Authorization was revoked on:* ___________ *per request of:* _________________________
date

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Legal Agreement

Dear consumer or patient: In agreeing to see you for psychological services (e.g., testing, group, and/or psychotherapy), we would like to make it safe for all parties to talk to our clinicians. In order for us to make it safe for you to share whatever information that needs to be shared with our clinicians, we ask that you sign this statement agreeing that neither our clinicians nor our records, regarding your treatment will be subpoenaed. We want to be clear to our clients at the beginning of the treatment process that information shared with us will not be used for or against you in a court of law. Before signing this agreement we ask each of you to check with your attorney to make sure he/she has no objections to your signing.

To Parent or Guardian: In agreeing to see your child for psychological services (e.g., testing, group, and/or psychotherapy) and you, his/her parents, for parent counseling, we would like to make it safe for all parties to talk to our clinicians. In order for us to make it safe for you and your child to share whatever information that needs to be shared with our clinicians, we ask that each of you sign this statement agreeing that neither our clinicians nor our records, regarding treatment for your child and the accompanying parent counseling, will be subpoenaed. We want to be clear to both parents at the beginning of the treatment process that information shared with us will not be used for or against either parent in a court of law. Before signing this agreement we ask each of you to check with your attorney to make sure he/she has no objections to your signing.

Our Policy: To provide consent for treatment for a child you must either have sole legal custody OR shared legal custody OR legal guardianship. **By signing below you are stating you have the legal right to consent for this child.** If you are divorced and share legal custody, by signing below you are stating you have told the other parent, or will tell the other parent expeditiously, you have brought the child to me for services. If you fail to do so, you may violate your court order.

Fees: In the event our clinicians and/or **records are subpoenaed please be aware of the following legal fees outlined below that are not covered by any insurance plan.** All court psychological services, with the exception of testimony, are billed at a rate of **$200 per hour.** Charges are calculated in 15-minute increments. We also bill for out of pocket expenses, such as travel, telephone calls, overnight delivery and courier services and the like. Please note that telephone or in person conferences are considered billable time. **Deposition or courtroom testimony is billed at a rate of $1500 per day minimum**. (In proceedings requiring an hourly billing rate, this would be $250/hour).

Signature (or NAME if not able to legally sign e.g., children or incapable adults) Date

Signature of Guardian or Parent (if applicable) Date

Signature of Guardian or Parent (if applicable) Date