Psychological Mobile Services PA

Professional Disclosure Statement
Clinical Team Members

Steven N Hannant, PsyD, MSCP. Licensed Psychologist NC#3681

HIGHEST EDUCATION

Post-Doctoral Master of Science: California School of Professional Psychology at AIU, San Francisco, CA. Clinical Psychopharmacology (APA) – 12/2013
Doctorate of Psychology: California School of Professional Psychology at AIU, San Diego, CA. Clinical Psychology (APA) – 11/2007

SPECIALTY AREAS OF INTEREST

❖ Pediatric Psychology & Special Populations |Psychological Testing & Evaluations |Psychopharmacology | Cognitive Behavioral Therapy (CBT)

Manijeh Boustani, PhD. Licensed Psychologist NC#1456

HIGHEST EDUCATION

Doctorate of Philosophy: Duke University, Durham, NC. Counseling Psychology – 1987

SPECIALTY AREAS OF INTEREST

❖ Therapy and Psychological Testing. Therapy with adults, children, parents, and families from an eclectic orientation involving Cognitive Behavioral Therapy (CBT)

Tommel Hayes, MSW. LCSW #C007416 & LCAS#1888

HIGHEST EDUCATION

Master of Social Work: East Carolina University, Greenville, NC. December 2003
Anticipated 2016 Doctorate of Clinical Social Work: Rutgers University, New Jersey

SPECIALTY AREAS OF INTEREST

❖ Mental health and substance abuse treatment to adults, children and families in private practice | Certified in sexual offender treatment

Regan Lee Hannant, MSW. LCSW #C005003

HIGHEST EDUCATION

Master of Social Work: East Carolina University, Greenville, NC. May 2003

SPECIALTY AREAS OF INTEREST

❖ Agency Director | Pediatric Therapy | Solution Focused Brief Therapy (SFBT) and Cognitive Behavioral Therapy (CBT)

Dorcas Miller, PhD. Licensed Psychologist NC#1873

HIGHEST EDUCATION

Doctorate of Philosophy: North Carolina State University, Raleigh, NC. Psychology – 1990

SPECIALTY AREAS OF INTEREST

❖ Therapy with Individuals, couples, groups involving an eclectic approach with attention to physical, intellectual, emotional, cultural, and spiritual areas

Alexis Kreske, MA. Psychological Associate NC#4325

HIGHEST EDUCATION

Master of Arts: North Carolina Central University, Durham, NC. Psychology – 12/2010

SPECIALTY AREAS OF INTEREST

❖ Psychological Testing and Evaluations | Pediatric Therapy | Individual, group, and family therapy with Cognitive Behavioral Therapy (CBT)

Matthew Mitchell, MSW, LCSW #C010351 & LCAS #21242

HIGHEST EDUCATION

Master of Social Work: East Carolina University, Greenville, NC, Social Work – 5/2014

SPECIALTY AREAS OF INTEREST

❖ Trauma Focused Cognitive Behavior Therapy (TFCBT) | Pediatric Therapy | Individual, group, and family therapy with Cognitive Behavioral Therapy (CBT)

Laura Nobles, MS. LPC#4599

HIGHEST EDUCATION

Master of Science: East Carolina University, Greenville, NC. – 12/2011

SPECIALTY AREAS OF INTEREST

❖ Individual, and family therapy with children, adolescents, and adults involving Cognitive Behavioral Therapy (CBT)
❖ Special needs and rehabilitative therapy

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CONFIDENTIALITY

The client has the right to privacy. Information disclosed by the client will be deemed confidential. Exceptions to this include: disclosure by the client (or knowledge of) harm to self or others, indications of child or elder abuse, or courts order. HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; and having any complaints you make about my policies and procedures recorded in your records. I am happy to discuss any of these rights with you. You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record and [information revealed to me confidentially by others]. These Psychotherapy Notes are kept separate from your Clinical Record. The Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

MINORS & PARENTS

While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information be shared with parents. It is my policy not to provide treatment to a child under 14 unless he/she agrees that I can share whatever information I consider necessary with his/her parents. For children 14 and over, I request an agreement between my patient and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

CONTACTING OUR CLINICIANS

Due to our work schedule, we are often not immediately available by telephone. We are usually working between 10:00am and 7:00pm and will not answer the phone when with a client/member. The telephone is answered by an office staff, assistant or by voicemail. If the message is urgent, however not an emergency, we will make every effort to have your call returned within 48 hours, with the exception of weekends and holidays. We will generally return calls if there is a client/member cancellation between 10:00am and 7:00pm. You should know that there are times we not available for emergencies. In agreeing to see one of our clinicians you are accepting this limitation in emergency coverage. If you are unable to reach us and feel that you can't wait for your call to be returned, contact your medical doctor, family physician or the nearest emergency room. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary. In the event of an emergency contact your local emergency services or call 911 (depending on the severity level). Please check our website contact page for updated crisis protocol: www.psychologicalmobile.com/contact or if after hours call our after hours crisis number if necessary: 919-252-4816.

NORTH CAROLINA PSYCHOLOGY BOARD

The practice of psychology is licensed and regulated by the North Carolina Psychology Board. All questions, concerns, and complaints regarding clinical practice may be addressed with this agency at www.ncpsychologyboard.org or 1-(828)-262-2258.

NORTH CAROLINA SOCIAL WORK CERTIFICATION AND LICENSURE BOARD

The practice of social work is licensed and regulated by the North Carolina Social Work Certification and Licensure Board. All questions, concerns, and complaints regarding clinical practice may be addressed with this agency at 1-800-550-7009 or http://ncswboard.org

NORTH CAROLINA BOARD OF LICENSED PROFESSIONAL COUNSELORS

The practice of professional counseling is licensed and regulated by the North Carolina Board of Professional Counselors. All questions, concerns, and complaints regarding clinical practice may be addressed with this agency at 844-622-3572 or 336-217-6007or http://www.ncblpc.org

MEMBER AGREEMENT

Signing this disclosure certifies that I have read the preceding information and understand my rights and responsibilities as a client. Legal guardians or parent must sign for clients under age 18. Special circumstances notice: Approved services may be delivered through technology-assisted media (e.g., TeleMental Health via internet web-cam) when deemed necessary due to special circumstance (e.g., service delivery to distance location, time restraints and/or availability). In addition, if psychological testing is requested or deemed necessary for treatment purposes I agree and understand that the licensed psychologist, and/or the trained/supervised testing technician(s) may administer and/or score testing (as permitted).

X _____ _____

Member or Parent / Guardian's **Signature** Date

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 ☐ CPP ☐ WPP

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**): _____

School & grade or Occupation: _____

Referral Source: _____

Doctor / NPI*: _____

***Note:** Medicaid members require a physician or psychiatrist referral for testing & therapy*

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

☐ **SEE ATTACHED COPY OF CARD(S)**

Primary Insurance & policy #: _____

Customer Service/Mental Health # & Subscriber name: _____

Secondary Insurance: _____

Insurance/Subscriber #: _____

Complete if insurance is MEDICAID or NCHC:

Social Security #: ☐decline_____ **Reported *Gross Yearly Income*:** _____

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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.

Consent for Emergency Care

I consent to Emergency Medical Care: This is to authorize Psychological Mobile Services, PA to seek emergency medical care if needed. It is understood and agreed that the staff and Psychological Mobile Services, PA will be held harmless for any and all results of the staff's efforts to obtain emergency medical treatment including any accident or injury while being transported. If the director of the program deems emergency medical care necessary, and neither I nor any person named below can be reached, I authorize the person in charge to procure medical care and to act on my behalf in granting permission for the above named individual/client to receive treatment or surgery. **In case of emergency contact:**

Name: _____ Relationship: _____ #: _____

Hospital or Doctor Preference: _____ #: _____

Consent to use or disclose information for treatment, payment, and health care operations.

Federal regulations (HIPAA) allow us to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you to obtain payment for services we provide, and for other professional activities (known as "health care operations.") Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time. You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do not agree to a restriction, that agreement is binding. Note: we reserve the right to exchange information with other mental health, substance abuse, or health providers for the coordination of your treatment. If you do not want information exchanged by providers you must request and sign a non-disclosure form, per NC Statute 122C Article 3. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance to the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

Treatment Services:

Psychological Mobile Services, PA charges for an initial Psychiatric Diagnostic Evaluation the first appointment. This evaluation helps formulate an initial diagnosis and treatment recommendations. After the initial appointment fees vary depending on the type of service (e.g., group vs. individual therapy) and clinician qualifications (e.g., Doctorate vs. Masters). Please refer to the "Fee Schedule" for details. The Fee Schedule is updated annually around April 1st based on yearly inflations. Fees for psychological testing are billed by the hourly rate or by the type of test battery and involve time to administer, score, interpret, and produce a typed report. Rates for psychological testing vary depending on the type of evaluation and the tests involved. Please refer to the "Fee Schedule" for more information. We also charge for other professional services you need, though the charge will be pro-rated fee for periods of less than one hour. Other services include letter or report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries necessary for the authorization of services by insurance or managed care companies, and the time spent performing any other services you may request.

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Treatment information:

- ✓ When seeing children whose parents are separated or divorced, the parent initiating the service with me will be financially responsible. Psychological Mobile Services, PA does not bill another person or an estranged spouse unless that person notifies us in writing that he or she is accepting payment responsibility.
- ✓ Payment for services is due when services are provided.
- ✓ As a courtesy to patients and families, our office will bill your insurance company in accordance with information you provide. **However, you (not your insurance company) are legally responsible for full payment of my fees.** You are expected to pay any deductible or co-pay required under your insurance plan, at the time of service. If your insurance company sends the payments to you instead of our office because **Psychological Mobile Services, PA is not contracted with them, you are expected to pay in full at the time services are provided.**
- ✓ A monthly service fee of $10.00 will be added to any balance outstanding for more than 60 days. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, our office has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require the disclosure of otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If legal action is necessary, its costs will be included in the claim.

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.

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.

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.

X _____ _____

Member / Guardian Sign ***Date***

Witness: **X** _____ _____

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

Psychological Mobile Services PA

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

Reason for Disclosure:

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

Specific Information to be disclosed:

- ☐ Therapy records
- ☐ Protected Health Information (PHI)
- ☐ Evaluations / treatment summaries
- ☐ Substance Abuse 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.
- Also, information regarding drug and alcohol use is protected under federal guidelines and cannot be released without your consent; therefore, you have the right to specifically authorize or refuse disclosure of substance abuse or HIV/AIDS information and if you refuse disclosure of said information, simply state you refuse disclosure here by checking here: ☐ **Refuse** and providing your **Initials** _____.
- 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