Banner Consulting and Counseling

2525 Raeford Road, Suite B
Fayetteville NC 28305
910-491-8901 phone
910-491-8902 fax

REGISTRATION FORM

****PLEASE MAKE SURE OFFICE STAFF COPIES YOUR INSURANCE AND ID CARD****

Section I (Patient/Client Information)

Date: ____________

Name:___________________________ Nickname:_____________________ Age:______ Date of birth:___________

Address:____ City:_____________ State:_______ Zip:__________

Phone: __________________________ Work:______________________ Cell:_______________________

The best phone to contact me (my parents) on is:
- ☐ Home
- ☐ Work
- ☐ Cell

Text Reminders? __________

Gender: _____________ Race: ______________

Please check appropriate box:
- ☐ Minor
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

If Student, Name of school:_______________________________ City:_________________________ State:____________________________
- ☐ Full-time
- ☐ Part-time

Person to contact in case of emergency:__________________________________ Phone:____________________________

Best days of the week and time of day that works best for your appointment: ________________________________

Do you have other family members that are seen here?

Section II (Responsible Party- Spouse or Parent/Guardian Information, if Patient is a Minor)

Relationship to Patient:
- ☐ Self
- ☐ Parent
- ☐ Spouse
- ☐ Other ______________________________

Name:____

Address:____

City:_____________________________________ State:___________ Zip:___________ Phone:____________________________________

Employer:____ Work Phone:____________________________________

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Section III (Insurance Information)

Please Check Insurance Company Below:

- ☐ BlueCross BlueShield
- ☐ Aetna
- ☐ Medicare
- ☐ Medicaid
- ☐ Tri-Care
- ☐ United Healthcare
- ☐ Cash

Name of Insured:____ Date of Birth:______________________________

Relationship to Patient: ____

Name of Employer:____ Work Phone:____

Employer Address:____ City:_______________________ State:______________ Zip:___________

Insurance Company:____________________________________ Group #:__________________________ ID#:_____________________________

By providing this information, you are authorizing us to bill your insurance(s) for services provided to you and/or your family members

Secondary Insurance:__________________________________ Group #:_______________________ ID#:_________________________________

Section IV (Allergies) Please list all know allergies client may have:

____

____

____

____

Section V (Additional Family Members): If you would like to make an appointment for additional family members, please list them below:

Name	Age	Insurance Type
_____________________________	______	___________________________________
_____________________________	______	___________________________________
_____________________________	______	___________________________________

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New Client Signature Page

Name (Printed): ____________________________ Date of Birth: _______________

1. **The information provided on the registration paperwork is true to the best of my knowledge.**
2. **By the signature below, I authorize independently contracted therapists who are contracted with Banner Consulting and Counseling of North Carolina, PLLC to treat myself or the above name family member.**
3. **I have received, read, and understand the Bill of Rights for Medicaid and Tricare, BCCNC office policies, and Patient's Right's.**
4. **I hereby acknowledge that I have received and have been given an opportunity to read Banner Consulting and Counseling of North Carolina service's notice of privacy practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact the owner of Banner Consulting and Counseling of North Carolina.**
5. **I understand that if I am experiencing an emergency or am in crisis, I can call or go to the nearest crisis and Assessment center, call 911, or go to the nearest emergency room. Also, if available I can call the 24-hour Access and Information Line provided by my insurance.**
6. **I acknowledge that I have received a card containing the contact information of my individual contracted therapist.**
7. **In the event of an emergency, my signature below grants permission for the employees and/or contracted therapist to seek emergency medical care on my behalf from a hospital or physician.**

Client Signature:_________________________________ Date:___________________

Parent/Guardian Signature: _________________________ Date: ___________________

Parent/Guardian Printed Name: ______________________

Client refused to acknowledge receipt of Notice of Privacy Practices ____________________________________ Staff Signature

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If you do not understand the following, please discuss with administrative staff before you sign.

1. Banner Consulting and Counseling of North Carolina is a professional limited liability company.
2. Each individual therapist is independently contracted with the above company. They are not employees of the above company.
3. It is our intention at BCCNC that you get the help YOU need. It is important, therefore that your therapist is a good fit for you (or your family member). Please let your independently contracted therapist know exactly what your expectations are and the changes you are looking for. Do this during your first session. If you believe at some point that it is not a good fit, please ask your therapist about this first to see if adjustments can be made. If you discover it is still not a good fit, please ask your therapist for a referral to another therapist who is independently contracted with BCCNC who may fit you better. You may also contact the main office to request this referral.

FOR SELF-PAY CLIENTS ONLY:
As a self-pay client, I agree to pay the current rate set by my independently contracted provider.
I attest that:

a) I do not have insurance coverage, OR
b) I have insurance coverage but choose not to use it, and understand that in doing so I am waiving any right to reimbursement, OR
c) I have insurance coverage but understand that my services are not covered by the plan.

Signature: ___________________________ Date: _______________

FOR INSURANCE CLIENTS ONLY:
I authorize any insurance benefits to be paid directly to BCCNC (Banner Consulting and Counseling of North Carolina, PLLC), Carol Duke, LCSW, or any of its Independently contracted therapist who provide services to me or my family members. I understand that I am financially responsible for any balance. I also authorize BCCNC (or the entities listed above) and/or insurance company to release information required to proves my claim.

Signature: ____________________________ Date: _______________

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CLIENT FINANCIAL RESPONSIBILITY FORM

Fees that may be billed to clients that are not covered by insurance companies include:

-Co-payments and deductibles: vary based on your insurance company

-Missed appointments/No Shows with less than a 24-hour notice that are not emergencies: $50; if you arrive more than 10 minutes late to an appointment you may be charged the missed appointments fee, and rescheduled

-Letters for legal issues: $100

-Letters for Emotional Support Animals: $50

-Request for documents: $100 per hour to prepare

-Phone calls or emails outside of sessions to clients, lawyers or Social Services: $50 per hour

I hereby authorize ______________________________ at Banner Consulting and Counseling of North Carolina, to charge my credit or debit card for any applicable fees that are not covered by insurance.

Client name as it appears on card: __________________________________

Type of card (circle one) Visa Mastercard

Expiration Date: ____/____ Card Number: ________ ________ _______ _________

CVV_________

Billing address:____

Card Holder Signature:____ Date:__________

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**Banner Consulting
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GAD-7

Over the last two weeks, how often have you been bothered by the following problems?

0. Not at all 1. Several Days 2. More than half the days 3. Nearly every day

Feeling nervous, anxious, or on edge	______
Not being able to stop or control worrying	______
Worrying too much about different things	______
Trouble relaxing	______
Being so restless that it is hard to sit still	______
Becoming easily annoyed or irritable	______
Feeling afraid as if something awful might happen	______

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PATIENT HEALTH QUESTIONNAIRE – 9

Over the last two weeks, how often have you been bothered by the following problems?

0. Not at all 1. Several Days 2. More than half the days 3. Nearly every day

Little interest or pleasure in doing things	______
Feeling down, depressed, hopeless	______
Trouble falling asleep/staying asleep	______
Sleeping too much	______
Feeling tired or having little energy	______
Poor appetite or overeating	______
Feeling bad about yourself	______
That you are a failure or have let yourself or your family down	
Trouble concentrating on things, such as reading the newspaper	______
Or watching television	
Moving or speaking so slowly that other people have noticed	______
Or the opposite- being fidgety or restless more than usual	
Thoughts that you would be better off dead or hurting yourself	_______
In some way	

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ **Not difficult at all**
- ☐ **Somewhat difficult**
- ☐ **Very difficult**
- ☐ **Extremely difficult**

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OFFICE POLICY

APPOINTMENTS MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE:

- **Your insurance company will not pay for a missed session. In order for the independently contracted therapists to continue to provide services to those who need them. ALL appointment times must be filled with only those who desire to be at their appointment at the designated time.**
- **"No-Shows" and last-minute cancellations means that time slot cannot be filled with another client who may be waiting for an opening.**
- **If you do not show up for an appointment or call to cancel at the last minute, there is a $50.00 fee. (Real emergencies are an exception). If this happens more than once, your therapist may decide to take you off the "standing" (same appointment time/day every week) schedule so that someone else may have that time slot.**
- **Please do not schedule an appointment if you are not sure you can be there. Just call back to schedule when you know for sure.**
- **If you know ahead of time that you will be out of town or unable to attend your standing appointment, please let your therapist know right away so they can put that in their calendar and that time will be available to someone else.**

IF YOU ARE HAVING A CRISIS OR EMERGENCY:

- **Using the appointment care that was given to you, call or text your therapist.**
- **If available, call the 24-hour Access and/or Information line provided by your insurance.**
- **Call or go to the nearest crisis and assessment center**
- **Call 911**
- **Go to the nearest emergency room**

YOUR TREATMENT IS CONFIDENTIAL AND IS SHARED WITH NO ONE WITHOUT YOUR WRITTEN CONSENT. (FOR CHILDREN, NO INFORMATION IS SHARED WITH OTHERS WITHOUT PARENT/GUARDIAN'S WRITTEN CONSENT)

THERE ARE 4 EXCEPTIONS TO THIS RULE:

- **The underage client is identified to be a danger to themselves or others. The parents will be informed. (Some children prefer to talk to therapist alone at times, please be assured that you will be informed if your child is suicidal or is wanting/planning to hurt someone else)**
- **The adult client is identified to be a danger to others (homicidal)**
- **Information required to be released by a legal/appropriate subpoena or court order**
- **Suspected abuse/neglect of a minor/elder/incompetent adult.**

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IF YOUR CHILD IS CURRENTLY OR SOON TO BE INVOLVED IN A CUSTODY OR COURT CASE OR IF YOU SUSPECT SEXUAL OR PHYSICAL ABUSE, PLEASE NOTIFY THE INTAKE WORKER OF THOSE ISSUES FIRST.

AUTHORIZATIONS:

- **Please familiarize yourself with coverage and authorization procedures of your insurance company's Behavioral Health Service, including criteria for continued sessions.**
- **Banner Consulting and Counseling will take care of all authorizations for you. Please be assured we will only provide the basic info necessary for this procedure. If you have concerns about this process, please discuss this matter with your therapist.**
- **Medicaid authorizations require BCCNC to obtain a "Service Order" from your doctor.**

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HIPAA INFORMATION/NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your health record contains personal information about you and your health. This info about you that may identify you and that relates to your past, present, and future physical or mental health or condition and related health services is referred to as Protected Health Information (PHI). This notice of privacy practices describes how we may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing you one at your next appointment.

HOW MAY WE USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

FOR TREATMENT:
Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or peer review members. We may disclose PHI to any other consultant only with your authorization.

FOR PAYMENT:
We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

FOR HEALTH CARE OPERATIONS:
We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to: quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (ex: billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization. Your PHI will also be used to remind you of your appointments.

USES AND DISCLOSURES REQUIRING AUTHORIZATIONS:
You may give written permission which allows us to use or disclose PHI for purposes other than treatment, payment, or healthcare operations. We will always obtain your written permission before releasing your psychotherapy notes which are notes about our conversations during private, group, joint, or family counseling sessions. These notes are given a greater degree of protection than PHI.

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REVOCATION OF AUTHORIZATION:
You make revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action on the use or disclosure indicated in the authorization. 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, you may not I

USES AND DISCLOSURES WITHOUT CONSENT OR AUTHORIZATION:
We may use or disclose PHI without your consent or authorization in the following circumstances: instances of child abuse, instances of adult and domestic abuse of a disabled adult, health oversight, judicial or administrative proceedings only as required by law, serious threat to health or safety, medical emergency, worker's comp claims, or as required by law.

YOUR RIGHTS REGARDING YOUR PHI:
You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to your therapist.

- **Right of access to inspect copy:** You have the right, which may be restricted only in exceptional circumstances to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you.
- **Right to request amendment:** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not a required to agree to the amendment.
- **Right to accounting disclosures:** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in a twelve-month period.
- **Right to request restrictions:** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. We are not required to agree to your request.
- **Right to request confidential communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a copy of this notice:** You have a right to a copy of this notice.

COMPLAINTS:
If you believe we have violated your privacy rights and wish to file a complaint with this office, you may send your written complaint to this office or you may contact your therapist. You may also send a written complaint to the Secretary of the US Department of Health and Human Services. You have specific rights under the Privacy Rules. No retaliation will be taken against you for exercising your rights.

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PATIENT RIGHTS FOR MEDICAID CONSUMERS

- You have the right to consent to treatment, withdraw from treatment, or refuse treatment at any time.
- You have the right to treatment and access to medical care and habilitation regardless of age or degree of mental health/IDD/SA Disability.
- You have the right to confidential treatment. No information about your treatment shall be released without your written consent except in an emergency or as provided for in general statutes: 122c 152 through 122c 156.
  - The provision of services to you is not contingent upon the above release.
  - Information may not be disclosed if Federal Statute prohibits disclosure.
- You have the right to secure storage of your records.
- You have the right to receive a written copy of your individual treatment plan. To obtain a copy of your treatment plan, contact your independently contracted therapist directly or call the office at 910-491-8901.
- You have the right to contact Disability Rights North Carolina:
  - Phone:919-856-2195 or 877-235-4210 (888-268-5535 TTY)
  - Website: www.disabilityrightsnc.org
  - Address: 2626 Glenwood Ave, Suite 550, Raleigh, NC 27608
- You have the right to access your provider. You will be given the personal cell phone number of the therapist providing care to you. Messages may be left on your provider's voicemail or you may send a text message to schedule an urgent appointment with your therapist.
- If experiencing an emergency or are in crisis , contact your therapist, call the 24-hour access and/or information line provided by your insurance's LME, call or go to the nearest crisis and assessment center, call 911 or go to the nearest emergency room.

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Rights and Responsibilities for Tricare Beneficiaries

As a TRICARE beneficiary, you have rights regarding your health care and responsibilities for participating in your health care decisions.

PATIENTS RIGHTS:

As a patient in the Military Health System, you have the right to:

- Easy-to-understand information about TRICARE
- Your choice of health care providers
- Emergency health care services when and where you need it
- Review information about the diagnosis, treatment, and progress of your condition
- Fully participate in all decisions related to your health care or to be represented by family members, conservators, or other duly appointed representatives if you are unable to fully participate in treatment decisions
- Considerate, respectful care from all members of the health care system without discrimination base on race, ethnicity, national origin, religion, sex, age, metal or physical disability, sexual orientation, genetic information, or source of payment
- Communicate with health care providers in confidence and to have the confidentiality of your health care information protected
- Review, copy, and request amendments to your medical records
- A fair and efficient process for resolving differences with your health plan, health care providers and the institutions that serve them

PATIENTS RESPONSIBILITIES:

As a patient in the Military Health System, you have the responsibility to:

- Maximize healthy habits, such as exercising, not smoking, and maintaining a healthy diet
- Be involved in health care decisions, which means working with providers in developing and carrying out agreed-upon treatment plans, disclosing relevant information and clearly communicating your wants and needs
- Be knowledgeable about TRICARE coverage and program options, including covered benefits; exclusions; rules regarding use of network providers; coverage and referral rules; appropriate processes to secure additional information; and appeals, claims, and grievance processes
- Be respectful of other patients and health care workers
- Make a good-faith effort to meet financial obligations
- Follow the claims process and to use the disputed claims process when you have a disagreement concerning your claims
- Report any wrongdoing or fraud to the appropriate resources or legal authorities

In the event of an emergency call 911 immediately or go to the nearest emergency room

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New Client Information

Please remember:

- To arrive to your appointment on time
    - You do not have to check- in, just have a seat in the waiting area
    - Your therapist will come and get you from the waiting area when your appointment starts
    - Please do not go in therapist's office earlier than your appointment, even if you see the door open.
- Your appointment will end on time
- Your insurance probable pays for 2 sessions per week
    - Please talk to your therapist if you want to increase or decrease your number of sessions per week
- If you cannot make the appointments, tell your therapist so they can take you off the calendar
    - Please inform your therapist in advance, so that we may provide that slot to someone who is in of an appointment.
    - Please note the cancellation policy that you signed. You must give 24-hour notice if you will not be at your appointment, or you will be taken out of the calendar (You can start appointments again after you pay the $50 fee)
- The first time you are scheduled with your therapist, you will receive their appointment card, which has the contact information for your therapist
    - We suggest saving the information in your phone so you will have easy access