Teresa R. Helms, Psy.D.

Licensed Psychologist

6706 Roberta Road, Harrisburg, NC 28075

3111 Springbank Ln, Ste G, Charlotte, NC 28226 • 6650 W Indiantown Road, Suite 210, Jupiter, FL 33458

Today's Date:_____ Referred By:_____

PATIENT INFORMATION

Name:_____

Date of Birth:____/____/____ Age:_____ Social Security #:_____

Home Address:_____

City:_____State:_____Zip:_____ Email:_____

Employer: _____ Occupation:_____

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

Named of Spouse or Partner (if applicable) _____

Full Name of Children (in birth order)	Age	Name	Age
1.)_____	____	3.)_____	_____
2.)_____	____	4.)_____	_____

Others Living at Home:_____ Relationship:_____

Home Phone:_____ Okay to call and leave message? _____

Work Phone:_____ Okay to call and leave message? _____

Cell Phone:_____ Okay to call and leave message? _____

Emergency Contact:_____ Relationship:_____

Phone Number:_____

Primary Care Physician:_____ Phone #:_____

Psychiatrist: _____ Phone #:_____

Address:_____ City:_____ State:_____

INSURANCE COVERAGE

Primary Insurance Company:_____ Phone#:_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder:_____ Relationship to Patient:_____

Mental Health Covered?_____ Prior Authorization Needed?_____ Date:_____

Member Number:_____Group:_____

Birthdate of Policy Holder:_____Employer of Policy Holder:_____

I hereby authorize Teresa R. Helms, Psy.D., to furnish information to insurance carriers listed above concerning my condition and treatment. I hereby assign to the psychologist all payments for services rendered to me. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature_____Date_____

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OFFICE POLICIES AND PROCEDURES

Appointments: I am available for appointments Monday - Friday. The therapy hour is 45-60 minutes long. You can make appointments by contacting me directly. If your schedule permits, negotiating a standing appointment saves time and ensures your access to the times that work best for you.

Confidentiality: Our communication and your medical records are confidential and highly protected. No information can be released without your authorization. Exceptions to confidentiality occur when there is clear intent on your part to harm yourself or someone else; if I suspect abuse or neglect of a child, elderly or disabled adult; or you are involved in a workman's compensation claim. In rare cases, the court or licensing board may subpeona records. These exceptions are based on existing laws. I adhere to all federal regulations of the Health Insurance Portability Act (HIPAA), which outlines patient privacy protections and patient rights.

Cancellations: When your plans change for any reason and you cannot keep your appointments, please call and give as much notice as possible so I can make the time available for others who need to see me. You will be expected to pay full fee for any session that is not cancelled at least 24 hours in advance. Insurance does not cover missed appointments. I will work with you on a payment plan if necessary, however, payment toward the fee must be made at the next appointment time.

Professional Fees: The fee for an hour session is $170.00. The initial consultation is $175.00. Forty-five minute sessions are $150.00. Thirty-minute sessions are $100. I will bill on a prorated basis for other services such as report writing, letters, telephone consultations, and any other documents you ask me to complete for you. There are no charges for calls to schedule sessions or conduct brief items of business.

Payment: Payments, copayments and deductible amounts are due at the time of service. Checks should be made out to "Teresa R. Helms, Psy.D." There will be a $25.00 fee for all returned checks. If you do not wish to use your benefits, full payment is expected at the time of service. Upon request, I can provide you with the necessary documentation to file directly with your insurance carrier for reimbursement.

Insurance: Health insurance is a contract between you and your employer and your health insurance company. Each policy has different rules regarding which services are allowed, deductible amounts, how you are charged, etc. You are responsible for knowing the terms of your health contract benefits. I need all the information on the "intake sheets" as well as a copy of your insurance cards if applicable. As a service to you, I file claims for all insurance plans with which I participate. However, should your insurance deny a claim, you are responsible for your payment in full. Any balance due after your insurance company pays or denies your claim is payable BY YOU when billed.

Prior approval is required for most mental health treatment. You are responsible for getting the initial authorization number. Please make sure to get the number for me prior to our first session. If not, I will ask you to use my phone to get that number prior to being seen and that will cut into our time to talk. Additionally, some policies require that you are referred to me by your primary care physician. In those cases, you must be certain that he/she knows to send me such referral. I must have such a referral in hand before we can proceed.

You may be limited by your policy in the number of mental health visits per year allowed or you may have a dollar limit ("cap").

You are responsible for informing me of any changes in your insurance or demographic information.

Claims may be filed electronically. It is important to be aware that by filing claims with insurance companies, I am at a minimum to provide a mental health diagnosis. Some benefit plans require more detailed information. This information will become part of your permanent health record.

The advantage of using insurance benefits is that they will cover a portion of the fee. However, the disadvantages include that you may need permission for treatment. I will be required by your insurance company to provide a psychiatric diagnosis, a third party will have access to your records and reimbursement may be terminated before treatment needs are met. While the disadvantage of self-paying is that the full fee comes out of your pocket, self-paying allows a higher degree of confidentiality in addition to providing greater flexibility and autonomy in designing a treatment program.

Please remember that you, not your psychologist, are the policyholder. If your insurance fails to pay on a timely basis (within 90 days), I will send you a Statement of Account notifying you that your claim is unpaid at which time you/your employer must assist in pursuing your benefits.

Phone Calls and Messages: I strive to return phone calls promptly, but inevitably there can be delays. If I am unreachable for a period of several days (such as vacation, etc.) I will specify this on my confidential voice mail.

Emergency Procedures: If you feel that you are having difficulties, you are encouraged to call me as soon as possible to schedule an appointment. If my office schedule is full, I will arrange a time for a telephone consultation for which there will be a charge. If you are having a serious crisis, if it is after hours, during the weekend or while I am out-of-town, several options are available to you, You may try calling me. If you cannot reach me, you may call your family physician or your psychiatrist. If it is an acute emergency that cannot wait, go to your nearest hospital emergency room or dial 911.

Session Etiquette: When you come for your appointment, please come in and have a seat in the waiting room. I will come and get you at the time of your appointment. Our session will be for 45 - 60 minutes. Please help me stay on time by having your check written prior to the beginning of the appointment.

The therapeutic relationship is a psychologically intimate, but strictly professional one. It is my absolute commitment and a requirement, that our relationship be limited to our therapy appointments and necessary telephone contacts. I will follow your requests about where to contact you and how to identify myself if I need to contact you.

If you are dissatisfied with any aspect of my work, please inform me immediately. This will make our work together more efficient and effective. If you think you have been treated unfairly or unethically by me or any psychologist and cannot resolve this problem with me, you can contact the North Carolina Psychology Board or Florida Department of Health for clarification of client rights as I've explained them or lodge a complaint. If you have any questions, feel free to ask.

Notice of Termination: You are not obliged to see me for any specific number of sessions. It is important, however, to give me one session's notice before ending. What I want to avoid is a situation where you cancel and then don't reschedule without explanation. A clean ending to our time together will be important for both of us.

Please sign and date this form. A copy for your records will be provided for you. I will retain a copy in my confidential records.

I understand and agree to the terms specified above:

Patient
Signature:_____

Date:_____

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MEDICAL HISTORY

Patient's Name: _____ Date: _____

Emergency Contact: _____ Phone: _____

ALLERGIES: _____

_____

Primary Care Physician: _____

Date of last physical examination: _____ Height: _____ Weight: _____

All current medications and dosages (state beginning date): _____

_____

_____

Past Psych Medications (and side effects): _____

_____

_____

Have you had trouble with:		
Thyroid Disease	Y	N
Shortness of breath	Y	N
Chest pain / heart attack	Y	N
Irregular heartbeat	Y	N
Stroke	Y	N
Seizure	Y	N
Cancer	Y	N
Diabetes	Y	N
Head injury	Y	N
Surgeries	Y	N
Hospitalizations	Y	N
Hypertension	Y	N

Pregnant now? _____ Trying?_____

Method of Birth Control:_____

_____

Date of Evaluation / Treatment:

_____

_____

_____

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Notice of Privacy Practices
Health Information Portability & Accountability Act (HIPAA) Law

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PLEASE SIGN OR REFUSE TO SIGN THE FOLLOWING FORM.

My office is committed to and practices the following guidelines to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private; to give you this notice of my privacy practices, and to let you know if I make any changes in them. I consider all information about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form", stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for payment purposes. (As needed for billing, insurance claims, and collections.) For treatment, health care operations and other cases, I will ask for your authorization for use and/or disclosure of your PHI. I may not disclose your PHI without your informed and voluntary written consent or authorization.

Disclosure of Information
Whenever your PHI is released or obtained, it will be the minimum information necessary. There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics.
These include:

- Emergencies
- Reporting abuse or neglect
- Disclosures required by court order
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public

Your Rights Regarding Privacy
By law, your have certain rights regarding the health information that I collect and maintain about you.
These rights include:

- The right to inspect and obtain a copy of your medical record.
- The right to request an amendment of any section of your medical record
- The right to request restriction of disclosure of your PHI for the purposes of treatment, payment, and healthcare operations.
- The right to request an accounting of the disclosures that we make of your health care information.
- The right to request confidential information.
- The right to a copy of this notice.
- The right to refuse to acknowledge receipt of this notice.

Questions and/or Exercising Your Rights
If you have any further questions and/or concerns about this notice please contact me. In order to exercise any of your right described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to my office. You may also complain to the secretary of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. I cannot and will not make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint. I reserve the right to amend the terms of this notice.

I WOULD BE HAPPY TO GIVE YOU A COPY OF THIS FOR YOUR RECORDS.

I received a copy of the Notice of Privacy Practices. Signature_____Date_____

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Credit Card Authorization Form

Card Name:_____

Credit Card Number:_____

Expiration Date:_____

Card Identification Number:_____

I authorize Dr. Helms to charge this card.

Signature_____

Name (Printed)_____

Date_____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____ Date of Birth_____

Hereby authorize:

Name:_____ Address:_____

Telephone:_____ City/St/Zip:_____

Fax:_____

To release my medical information to:

Name:_____ Address:_____

Telephone:_____ City/St/Zip:_____

Fax:_____

I authorize the use or disclosure of my personal health information as described below:

☐ Any and all records including mental health, HIV, Sexually Transmitted Disease, and/or substance abuse records covering the period of time _____ to _____.

☐ Other or exceptions:_____.

This information is being disclosed for following purpose(s): _____

_____

This authorization is valid until _____ (up to one year). I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke the authorization at any time and that I will be asked to sign the Revocation Section on the second page of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requestor of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g. insurance company) for the sole purpose of creating health information (e.g. physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment my be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

Signature_____ Date Signed_____ Print Name_____

Signature of Witness_____Print Name_____