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**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. We will not sell your information to anyone for any reason.
- 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 and nutritionists 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 her supervisor and/or clinical board in order to provide legal and ethical treatment. She may also do so to meet the requirements set forth for licensure or certification.
- I understand that all communications with Chrysalis staff, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician. I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cell phones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed, although any Chrysalis-based digital communications will utilize appropriate security measures.

I have read and understood this document and will address any concerns or questions with my therapist and/or the office manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

**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** \_\_\_\_\_

## **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 under the circumstances described in our Notice of Privacy Practices. Please read this Notice 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](http://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](mailto: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. If you object to any of these practices, you may discuss them with our staff and/or provide written documentation of your concerns. 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, understand its content, and agree to its stipulations.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Client (if guardian or representative): \_\_\_\_\_

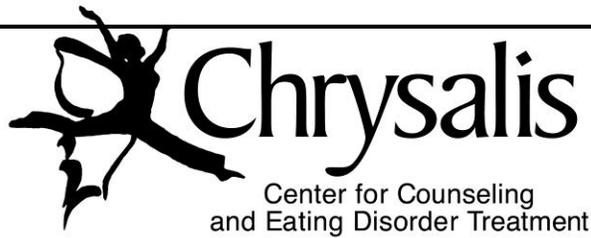
*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).*

I would like to opt out of receiving any fundraising, business or marketing communications from Chrysalis.

**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: \_\_\_\_\_



## OFFICE PROCEDURES AND FINANCIAL AGREEMENT

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

Chrysalis is a business office where a number of mental health professionals practice. Your contract for services is with our office 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 coverage. Acceptable methods of payment include cash, check, VISA or Master 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 up to \$60 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:**

As a courtesy to you, we will bill rendered services to your insurance carrier. We do not accept Medicaid. Insurance co-payments, coinsurances, and deductible payments are due at the time of service. However, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. 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.

### **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. Any balance not paid in 90 days will be subject to collections.

**Late Fees:** A late fee of \$25 will be charged to delinquent accounts that are not paid within 90 days of the issue date of the first bill and will also be referred to a third party collection agency. You will continue to 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 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.

**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.

**Additional Services:** Extensive services that involve clinical coordination and continuity of care may constitute an additional fee that is separate of therapeutic services. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to \$90/hour.

**Changes to the Policy:** Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

*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