Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

CONFIDENTIAL CLIENT INFORMATION

Welcome to Chrysalis Center Intensive Outpatient Program (IOP). Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal laws, any information you provide is strictly confidential.

Demographic Information:

Name: _____ SSN: _____ Date: _____

Mailing Address: _____

_____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which phone is the best way to contact you? _____ Is it okay to leave a message? Yes No

_____	_____	_____	_____	_____
Date of Birth	Age	Sex	Ethnic Group	Religious Preference

Relationship Status:

Single _____ Cohabitating _____ Married ___ Separated _____ Divorced_____ Widowed _____

Emergency Contact: _____

Telephone: (__) _____ Email: _____

Referral/Clinical Information:

How did you find out about our services? _____

What type of services are you seeking/expecting? (Please check all that apply to you)

_____ Intensive Outpatient Program
_____ Individual Counseling
_____ Group Counseling
_____ Couples/Family Counseling
_____ Nutritional Counseling
_____ Bariatric Evaluation
_____ Assessment

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? _____

What is your job title? _____

Education Information:

Highest Level of Education Completed:

Grade School _____ High School _____ College _____ Graduate School _____

Are you currently a student? Yes No

If yes, where? _____ Year _____ Major _____

Family/Significant Others:

If anyone in your family has a history of the following, please check all that apply and specify on the chart above: Mental Illness _____ Substance Abuse _____ Eating Disorder _____ Obesity _____ Dieting _____

Please provide the following information about your family members (include parents, stepparents, all siblings, spouse/partner, children, etc.) and significant others.

Name	Relationship to You	Age	Job/ Highest Education Completed	Where He/She Lives	Mental/Medical Conditions (mental illness, substance abuse, eating disorder, obesity, dieting)

Health Information:

Please list any chronic illnesses, injuries, physical conditions or disabilities: _____

_____

_____

Allergies/Adverse Reactions to Treatment: _____

_____

Primary Care Physician Name: _____

Date of Last Physical: _____ Telephone: (____) _____

Current Medications, Supplements, Vitamins	Daily Dose	Start Date	Name of Prescriber

Mental Health History:

Have you received counseling before? Yes No

If yes, when, where, what type, and with whom? _____

_____

Have you ever experienced any of the following?

_____ A recent and/or important loss (please specify)_____

_____ Physical Abuse

_____ Sexual Abuse/Molestation

_____ Sexual Assault

_____ Verbal/Emotional Abuse

_____ Suicidal Thoughts or Feelings

_____ Homicidal Thoughts or Feelings

Are you having current difficulties with any of the following?

_____ Self-Confidence/Self-Esteem

_____ Body Image

_____ Anger Management

_____ Peer Relationships

_____ Romantic Relationships

_____ Family Relationships

_____ Divorce/Separation

_____ Sexual Identity Issues

_____ Legal Problems

_____ Racial/Cultural Issues

_____ Other stress (please specify)_____

_____ Financial Problems

_____ Unemployment

_____ Learning Disabilities

_____ Loneliness/Social Isolation

_____ Career Planning

_____ Academic Performance

_____ Spirituality

_____ Decision Making

_____ Pregnancy (past, present)

How well are you getting along psychologically at this time?

_____ Very well, the way I want to.

_____ Quite well, no important complaints.

_____ Fairly well, but have ups and downs.

_____ So-so, can keep going with effort.

_____ Quite poorly, can barely manage.

_____ Very poorly, can't manage.

I**nstructions:** The questions below ask about things that might have bothered you or caused problems. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**. If the problem has happened in the past, even if it is resolved, please check "In the past."

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**In the past**	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (office use only)
I.	Little interest or pleasure in doing things?		0	1	2	3	4	
	Feeling down, depressed, empty or hopeless?		0	1	2	3	4	
II.	Feeling more irritated, grouchy, or angry than usual?		0	1	2	3	4	
	Feeling more tired than usual for no reason?		0	1	2	3	4	
	How long do these feelings usually last?							
	What is the longest they have ever lasted?							
III.	Sleeping less than usual, but still have a lot of energy?		0	1	2	3	4	
	Starting more projects than usual or doing more risky things than usual?		0	1	2	3	4	
	Feeling unusually high, charged up, excited or restless?		0	1	2	3	4	
	Had other people ever said that you were too high, charged up, excitable, or talkative?		0	1	2	3	4	
	How long have these moods usually last?							
	What is the longest they have lasted?							
IV.	Feeling nervous, anxious, frightened, worried, or on edge for days at a time, even when you didn't have anything special to do?		0	1	2	3	4	
	Feeling panic or being frightened?		0	1	2	3	4	
	Avoiding situations that make you anxious?		0	1	2	3	4	
	Have these feelings ever bothered you on and off for six months or more at a time? If so, how long did they last and when did this occur?							
	Feeling very afraid of certain things like heights, animals, needles, the sight of blood, lightening, etc?		0	1	2	3	4	
	What were you afraid of?							
	Feeling so afraid to leave home by yourself that you wouldn't go out?		0	1	2	3	4	
	Feeling afraid to go to supermarkets, go into tunnels, or use elevators?		0	1	2	3	4	
	Feeling so afraid of embarrassing yourself in public that you would not do certain things like eating in a restaurant, using a public restroom, or speaking out in a room full of people?		0	1	2	3	4	
	Did you see a doctor because of this and if so, what did the doctor tell you about these symptoms?							
	Having a lot of physical problems that have forced you to see different doctors?		0	1	2	3	4	
V.	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?		0	1	2	3	4	
	Feeling that your illnesses are not being taken seriously enough?		0	1	2	3	4	
	Doctors having difficulty finding what caused the problems?		0	1	2	3	4	

	Did you start having any of these problems before you were 30 years old? How old were you?							
VI.	Thoughts of actually hurting yourself?		0	1	2	3	4	
VII.	Hearing things other people couldn't hear, such as voices even when no one was around?		0	1	2	3	4	
	Feeling that someone could hear your thoughts or that you could hear what another person was thinking?		0	1	2	3	4	
VIII.	Problems with sleep that affected your sleep quality over all?		0	1	2	3	4	
IX.	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?		0	1	2	3	4	
	Having consistently had difficulty focusing and paying attention?		0	1	2	3	4	
	Feeling impatient, restless, and difficulty sitting still?		0	1	2	3	4	
	Others describing you as impulsive and/or hyper (e.g., do you tend to blurt out comments, interrupt others, say or do things you regret later)?		0	1	2	3	4	
X.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?		0	1	2	3	4	
	Feeling driven to perform certain behaviors or mental acts over and over again?		0	1	2	3	4	
	Doing things in an exact way or order even if it didn't make sense?		0	1	2	3	4	
XI.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?		0	1	2	3	4	
XII.	Not knowing who you really are or what you want out of life?		0	1	2	3	4	
	Not feeling close to other people or enjoying your relationships with them?		0	1	2	3	4	
	Being very worried or upset about something that happened to you, such as the death of a loved one, losing a job, getting separated or divorced, having a bad accident, getting a serious illness, etc.?		0	1	2	3	4	
	Having more trouble handling these situations than most people would?		0	1	2	3	4	
	Having flashbacks in which you found yourself reliving some terrible experience over and over?		0	1	2	3	4	
XIII.	Drinking at least 4 drinks of any kind of alcohol in a single day?		0	1	2	3	4	
	Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?		0	1	2	3	4	
	Using any of the following medicines ON YOUR OWN (without a doctor's prescription), in large amounts, or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?		0	1	2	3	4	
	Anyone remarking on or expressed concern about your use of alcohol or drugs?		0	1	2	3	4	
	Having drug or alcohol use cause other problems in your life?		0	1	2	3	4	

XIV.	Feeling fat even when other people express concern that you are thin enough or too thin?		0	1	2	3	4	
	Eliminating foods or restricting your overall food intake?		0	1	2	3	4	
	Eating so much you make yourself feel sick?		0	1	2	3	4	
	Eating to comfort, soothe, reward, or punish yourself?		0	1	2	3	4	
	Feeling that your eating was excessive and/or not really normal?		0	1	2	3	4	
	Feeling out of control when eating?		0	1	2	3	4	
	Worrying all the time about food or weight issues?		0	1	2	3	4	
	Feeling depressed, ashamed, or disgusted after eating?		0	1	2	3	4	
	Vomiting, using laxatives or diuretics, or exercising excessively to try to make up for eating too much?		0	1	2	3	4	
	Please fill out the *Eating and Body Image Check Sheet* form if you have had any of these issues, past or present.							
	Other feelings or symptoms that we have not mentioned? Specify:		0	1	2	3	4	

Have any of these symptoms -- drinking, drug use, moods, anxiety, etc. – ever interfered with school, work, or your job? What concerns, if any, have family and friends expressed? Please explain. _____

_____

_____

Have any of these symptoms ever gotten you into trouble with the authorities and/or caused legal problems? If yes, please explain. _____

_____

_____

Has your health ever suffered as a result of any of these symptoms? If yes, please explain. _____

_____

_____

Have you ever received medication or treatment for any of these symptoms? If yes, please explain. _____

_____

_____

Were you ever hospitalized for any of these symptoms? If yes, please explain. Please list any hospitalizations for psychological, psychiatric, or chemical dependency treatment, including location and dates. _____

_____

_____

_____

In your own words, please identify the concern(s) that you want to address in counseling. Be as specific as you can. _____

_____

_____

_____

_____

_____

_____

EATING AND BODY IMAGE CHECK SHEET

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CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

Client Name: _____ Date: _____

Weight History:

How tall are you? _____ Current Weight _____ Desired Weight _____

Lowest Weight _____ Date/age of this weight _____

Highest Weight _____ Date/age of this weight _____

How often do you weigh yourself? _____

Food History:

Restrictive Eating/Dieting (please check all that apply)

	Past	Current		Past	Current
skipping meals			fasting		
reducing portions			reducing calories		
restricting carbs			restricting fats		
restricting protein			restricting dairy		
chewing & spitting			throwing away food		

Have you ever deliberately lost so much weight that people expressed concern? Y N

Have you ever been afraid of getting fat even when other people said you were thin enough or too thin? Y N

Binging/Compulsive Eating (please check all that apply)

	Past	Current		Past	Current
eating sweets			eating a lot in a short period of time		
eating carbs			feeling out of control when eating		
eating dairy			eating until uncomfortably full		
eating to soothe self			eating until you felt sick		
eating to punish self			guilt/shame after eating		
depression after eating			eating for emotional reasons		

Specify binge foods _____

Have you ever felt that your eating was excessive and/or not really normal? Y N

Purging/Weight Control Measures:

Have you ever vomited, used laxatives or diuretics, or exercised excessively to try to make up for eating too much? Y N

Behaviors	Past	Current	# of times/pills per day	# of days per week
Vomiting				
Diet Pills				
Laxatives				
Diuretics				

	# of mins per day	# of days per week	Type & Duration
Current Exercise			
Past Exercise			

EATING AND BODY IMAGE CHECK SHEET

Possible contributors to eating and body image issues (check all that apply):

_____ teasing about appearance
_____ problems at school/work
_____ media influences
_____ family problems
_____ puberty
_____ medical reasons (illness/operation)
_____ depression
_____ death/loss
_____ recommendation of weight loss by: (circle one)
parent significant other friend physician
_____ other (please explain)_____

_____divorce
_____ difficulty coping with stress
_____ relationship issues
_____ leaving home/separation
_____ difficult sexual experience
_____ prolonged period of dieting
_____ body image dissatisfaction
_____ problems with friends

Physical Symptoms:

Which of the following are you currently experiencing?

_____ loss of period
_____irregular period
_____ nausea
_____ dizziness
_____ light-headedness
_____fainting spells
_____ weakness
_____ fatigue
_____ lack of energy
_____ sleep problems
_____acid reflux
_____ indigestion
_____ gas
_____ cramps
_____ other: _____

_____ bloating
_____ diarrhea
_____sore throat
_____ swollen glands
_____ ulcers
_____ dental problems
_____ irritated gums
_____chest pain
_____ irregular heartbeat
_____ shortness of breath
_____ frequent urination
_____ dehydration
_____ water retention
_____ excessive thirst

_____brittle hair
_____ hair loss
_____ dry skin
_____ yellowish skin
_____ coldness
_____muscle cramps
_____ muscle weakness
_____ loss of muscle
_____ tingling
_____ numbness
_____swelling of ankles
_____ swelling of hands
_____ fractures
_____injuries

Last physical exam: when, where & with whom? _____

Psychological Symptoms: Which of the following have you experienced?

_____irritability
_____depression
_____mood swings
_____mania/high mood
_____guilt
_____worthlessness
_____hopelessness
_____perfectionism
_____obsessive thoughts
_____following strict routines/rigid rules
_____engaging in rituals

_____difficulty making decisions
_____impaired concentration
_____memory problems
_____phobias
_____panic attacks
_____avoidance of social situations
_____fear of sex
_____promiscuous sexual behavior
_____risky sexual behaviors
_____thoughts of suicide
_____self-mutilation (cutting, burning, etc.)

Who knows about your eating disorder? _____
Other questions or concerns that have not been specifically addressed:_____

EDQOL Inventory

Client Name: _____

Date: _____

INSTRUCTIONS: Please answer the following statements according to how well they describe you in the last 30 days. Please be as open as possible. There are no right or wrong answers. Place an (X) under the appropriate column. For those items that do not apply to you, please leave them blank.

	In the last 30 days...	**In the past**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
I.	Psychological						
1	How often has your eating/weight resulted in you feeling embarrassed or "different"?						
2	How often has your eating/weight made you feel worse about yourself?						
3	How often has your eating/weight made you not want to be with people?						
4	How often has your eating/weight resulted in you believing that you will never get better?						
5	How often has your eating/weight made you feel lonely?						
6	How often has your eating/weight resulted in less interest or pleasure in activities?						
7	How often has your eating/weight led you to not care about yourself?						
8	How often has your eating/weight made you feel odd, weird, or unusual?						
9	How often has your eating/weight resulted in avoiding eating in front of others?						
II.	Physical/Cognitive						
10	How often has your eating/weight caused cold hands or feet?						
11	How often has your eating/weight caused frequent headaches?						
12	How often has your eating/weight caused weakness?						
13	How often has your eating/weight affected your ability to pay attention when you wanted to?						

(continued on next page)

	In the last 30 days...	In the past	Never	Rarely	Sometimes	Often	Always
14	How often has your eating/weight affected your ability to comprehend some verbal and written information?						
15	How often has your eating/weight reduced your ability to concentrate?						
III.	Financial:						
16	How often has your eating/weight led to problems with treatment provider(s) regarding cost of treatment?						
17	How often has your eating/weight led to you having difficulty paying monthly bills?						
18	How often has your eating/weight resulted in significant financial debt?						
19	How often has your eating/weight led to the need to spend money from savings or use your credit card frequently?						
20	How often has your eating/weight resulted in the need to borrow money?						
IV.	Work/School:						
21	How often has your eating/weight led to failure in a class or classes?						
22	How often has your eating/weight led to a leave of absence from work?						
23	How often has your eating/weight led to low grades?						
24	How often has your eating/weight resulted in reduced hours at work?						
25	How often has your eating/weight resulted in you losing a job or dropping out of school?						

The EDQOL has been reproduced with permission. Engel et al. (2006). Development and Psychometric Validation of an Eating Disorder Specific Health Related Quality of Life Instrument. *International Journal of Eating Disorders*, 39, 62-71.

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INTENSIVE OUTPATIENT PROGRAM RIGHTS & CONSENT TO TREATMENT

- ❑ I have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- ❑ I have the right to be treated in accordance with professional and ethical standards of conduct.
- ❑ I consent to take part in treatment with Chrysalis Center IOP. 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 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. Electronic records are maintained with a secure, dual firewall system called InSync. 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.
- ❑ I have the right to participate in the development of my IOP treatment plan and agree to do so upon admission to the program.
- ❑ I understand and give my consent for the Chrysalis Center 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 treatment providers will consult and share clinical information with their supervisor and/or clinical board in order to provide legal and ethical treatment. They 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 the confidentiality of these interactions cannot be guaranteed, although any Chrysalis-based digital communications will utilize appropriate security measures.
- ❑ I understand and consent to the standard behavioral contingencies that are used by Chrysalis Center IOP, including but not limited to meal replacement/supplementation, time outs, or removal from activities if my behavior warrants these interventions. Any non-standard interventions will be detailed in my individual treatment plan.
- ❑ I understand that I am responsible for managing my prescriptions and checking any prescriptions I will take while at CCIOP into the staff daily.
- ❑ I have the right to file a written grievance with the Practice Manager, if I feel that any of these rights have been violated. I also have the right to contact the Governor's Advocacy Council if they feel their rights have been violated.
- ❑ I have the right to discontinue treatment at any time. However, it is expected that you will confer with your primary therapist, primary dietitian, and the IOP treatment team rather than end treatment abruptly. In the normal course of events, at least 3 business days' notice will be required to adequately prepare for discharge. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other programs or professionals.
- ❑ I understand that this consent will be valid for the duration of this episode of treatment or for 6 months, whichever is longer. If I need to withdraw my consent for treatment, I will do so in writing and submit it to my primary therapist.

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** _____

Revised 06.23.2020
Date of NPP 05.25.2010

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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, 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 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.

☐ I would like to opt out of any research conducted at Chrysalis using outcomes data.

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: _____

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INTENSIVE OUTPATIENT PROGRAM PROCEDURES AND FINANCIAL AGREEMENT

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

Chrysalis Center's Intensive Outpatient Program (IOP) is a healthcare facility that treats adult participants with a primary diagnosis of an eating disorder. Your contract for services is with our facility and applies to any and all providers that serve in IOP.

SERVICES:

Chrysalis Center's IOP is an outpatient program that meets 3 days per week, 4 hours per day from 3 to 7 pm. Please arrive on time in order to ensure that you can participate in the entire program for the day Please arrive on time, as you cut down on your appointment time when you arrive late. The usual length of an IOP schedule per diem is 4 hours. This will include a combined variation of group therapy, meal group, and medical monitoring. If you arrive more than 15 minutes late to any scheduled service of your day, this will be considered a no-show for the day, and you will not be permitted to participate in the remainder of that IOP day. You will still be responsible for in a *late-cancellation* charge. Excused absences will be approved on a case by case basis by Clinical Director.

Professional fees (individual therapy and nutrition sessions, medication management, family/couple therapy) are charged separately from facility fees (IOP services include groups, check in, and meals). Please refer to the Office Procedures and Financial Agreement for those policies. Our facility files professional fees separately from facility fees for IOP services.

Late cancellations/No shows: Due to the IOP occupancy limits, these services cannot be occupied by another client. Therefore, **if you do not show up or late cancel for a scheduled IOP day, you will be charged a no-show fee of $100**. If you have a medical problem that requires you to miss IOP in order to go to the doctor on an emergent basis, the fee may be waived if you provide a doctor's note corroborating your visit (the note must include the time you were there, what you were treated for, and any treatment plan or medication that was provided). If you do not show up and have not contacted us, we will attempt to contact you and your emergency contact person if we are unable to reach you.

Please Note: any absences must be approved by the clinical director in order to be considered an excused absence and any planned absences must be requested at least one week prior to the day(s) you will not be here. 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 or Medicare in this program. Typically, insurance carriers require a prior authorization before admitting to an IOP program. Our staff will discuss with you what is needed to obtain the authorization and contact your insurance carrier before admitting to IOP. Our staff will notify you of the authorization details once it is received. 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 you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Payment plans may be arranged with the Practice Manager. Any balance not paid in 90 days will be subject to collections. Failure to adhere to your

payment plan is grounds for discontinuation of services. Note: 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.

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

Extensive services that involve clinical coordination and continuity of care may constitute an additional fee that is separate from IOP 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.

PAYMENT:

All IOP clients are required to place a credit card on file. Every Friday you will be charged the appropriate fees for that week, based on your insurance, deductibles, and co-pays. Outpatient services will be billed separately unless otherwise requested by the client. Payment is required, whether you are a self-pay client or have insurance coverage. All clients will be asked to put a credit card on file in order to facilitate this process.

Name (as it appears on the card): _____

Card Number: _____

Phone number of credit card holder: _____ Billing Zip code: _____

Expiration Date: _____ CVV/CVC: _____

Signature of Cardholder: _____

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 Practice 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.

_____ I understand that the credit card on file will be charged for IOP services on a weekly basis.

_____ _____

Signature of Client Date

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): _____

Address: _____

Telephone: _____

Birth Date: _____

Social Security Number: _____

Relationship to Policy Holder: _____

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

_____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

* Please see reverse side for secondary insurance information and consenting signature.

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

_____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

_____ _____

Name of Client (printed) Date

_____

Signature