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

## 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.
- ❑ I understand that if Chrysalis shares any information, we will adhere to the "minimum necessary" rule to protect your confidentiality and we will not share Psychotherapy Notes with any third parties.
- ❑ 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 and/or university in order to provide legal and ethical treatment. She may also do so to meet the requirements set forth for licensure or certification. If I am being seen by an intern, I understand that they are not yet licensed and are practicing under the auspices of their graduate program, not Chrysalis Center.
- ❑ 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** _____

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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 Kaitlyn Patterson, MA, LPA, Privacy Officer, at kaitlyn.patterson@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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## OFFICE PROCEDURES AND FINANCIAL AGREEMENT

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

Chrysalis is a business office where a number of mental health professionals, registered dietitians, and a psychiatric provider 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 scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. Appointment lengths vary depending on the type of provider seen. If you arrive more than 15 minutes late, you will 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 check is returned, you will be asked to arrange another method of payment.*

**All clients are required to place a credit card on file** in order to facilitate collection of payment. If estimated payment (copay, deductible, coinsurance, cash rates) is not received by the end of the date of service, the card on file will be charged. In the case that insurance reimburses different amounts than the estimated payment taken, credits and debits will be applied to the card immediately. If the card declines, you will have until one business day prior to your next appointment to provide current and valid card information or your scheduled session will be canceled and payment in full will be required before you can reschedule. A patient portal via our electronic medical records system will be provided to view and track payments.

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: _____

**Late cancellations/No shows:** For a missed or late cancelled appointment, you will be charged up to $60 for the appointment. Please note: both clinical and nutritional appointments must be cancelled no less than one business day before the scheduled appointment. 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.*

Unless otherwise notified, the insurance policy holder will be financially responsible for any balance on the client's account. Please make one of our administrative staff aware if the billing address is different than the home address on file. 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 our administrative staff. 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 may 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. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to $100/hour.

**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.

Please note: No provider at Chrysalis will fill out any disability forms (FMLA, short or long term, etc.) for clients who are not already established at Chrysalis (5+ sessions with one provider), and at the clinician's discretion. We will send records as requested to other providers or agencies with a valid Release of Information on file. If records are sent, there may be a $25 administrative fee associated with sending the records or filling out any paperwork for a third party.

**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 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 have been offered a copy of these policies to take with me if I desire.

_____ I understand that the credit card on file will be charged for services rendered if I do not make alternative arrangements at time of service

_____ I have discussed these policies and addressed concerns and questions with the administrative staff if needed. Initial and date by administrative staff if questions were addressed: _____

_____ _____

Signature of Client Date

*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.*

_____ _____

Signature of parent or Legal Guardian Date

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**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.*

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

**Please Note: Your insurance carrier requires us to gather this information in order to use your benefits, and the following information is not available on your insurance card. You must complete all fields on both pages of this form. If you do not provide us with accurate information, your claims may not be processed appropriately and you will be charged the full rate for services already rendered.**

**_____ Please initial if you do not want to use your insurance benefits; you will be charged the self-pay rate for services.**

**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: _____

**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

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## CONFIDENTIAL CLIENT INFORMATION

Welcome to Chrysalis Center. 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. ***These forms must be completed in their entirety prior to your first appointment, or you will not be able to see a provider at Chrysalis Center at that time.***

**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: _____ Gender: _____

Ethnic Group: _____ Religious Preference: _____

Relationship Status: _____Single _____Cohabitating _____Married
_____Separated _____Divorced _____ Widowed

Emergency Contact & Relationship to You: _____

Email: _____Telephone: (_____) _____

**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)

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

**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 below: _____ 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) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |

**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, 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?

_____ Academic Performance
_____ Anger Management
_____ Body Image
_____ Career Planning Issues
_____ Decision Making Issues
_____ Divorce/Separation Issues
_____ Family Relationships
_____ Financial Problems
_____ Learning Disabilities
_____ Legal Problems
_____ Other stress (please specify)_____
_____ Loneliness/Social Isolation
_____ Peer Relationships
_____ Phase of Life Issues
_____ Pregnancy Issues (past, present)
_____ Racial/Cultural Issues
_____ Romantic Relationships
_____ Self-Confidence/Self-Esteem
_____ Sexual Identity Issues
_____ Spirituality
_____ Unemployment

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.

In your own words, what brings you to counseling and what issues would you like to address. Also, please share any other relevant information that you would like us to know.

_____

_____

_____

_____

_____

_____

_____

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# COUPLES' INTAKE CHECKLIST

Client Name: _____ Date: _____

The scale below indicates different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the one that best describes the degree of happiness, all things considered, in your relationship.

| Extremely unhappy | Fairly unhappy | A little unhappy | Happy | Very happy | Extremely happy | Perfect |
|---|---|---|---|---|---|---|

Please check **one** of the following statements that best describes how you feel about the future of your relationship.

___ I want desperately for my relationship to succeed and I would go to almost any lengths to see that it does.
___ I want very much for my relationship to succeed and I will do all that I can to see that it does.
___ I want very much for my relationship to succeed and will do my fair share to see that it does.
___ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to make it succeed.
___ It would be nice if my relationship succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
___ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

Please indicate below how often the following items occur between you and your partner.

| | Never | Less than once a month | Once or twice a month | Once a week | Once a day | More often |
|---|---|---|---|---|---|---|
| Discuss or consider divorce, separation, or terminating the relationship | | | | | | |
| Leave after a fight | | | | | | |
| Regret that you got together | | | | | | |
| Quarrel | | | | | | |
| "Get on each other's nerves" | | | | | | |
| Think things are going well | | | | | | |
| Confide in your partner | | | | | | |
| Have a stimulating exchange of ideas | | | | | | |
| Kiss each other | | | | | | |
| Share outside interests or activities | | | | | | |
| Laugh together | | | | | | |
| Calmly discuss something | | | | | | |
| Work together on a project | | | | | | |

Most people have disagreements in their relationships. Please identify which areas you feel are current problems in your relationship and indicate with a checkmark the extent of the problem for those items:

| | Minor problem | Occasional problem | Significant, intermittent problem | Significant, ongoing problem |
|---|---|---|---|---|
| We fight all the time and never get anywhere | | | | |
| Spillover of other stress(es) in relationship | | | | |
| Issues with in-laws or other relatives | | | | |
| Financial issues | | | | |
| Sex life issues | | | | |
| Issues with household chores or errands | | | | |
| Issues with parenting/children | | | | |
| Violence in the relationship | | | | |
| Drug or alcohol use/abuse | | | | |
| Extra-relationship affair/flirting/jealousy | | | | |
| Emotional distance | | | | |
| Relationship is becoming passionless or non-romantic | | | | |
| Not dealing well with another life change (one or both of you) | | | | |
| We have basic differences in values/goals/lifestyle preferences | | | | |
| We are not working as a team | | | | |
| We don't have fun together anymore | | | | |
| Spiritual issues | | | | |
| Friend/community issues | | | | |
| Neither of us is willing to give in on particular issues | | | | |
| We don't express affection or caring to each other | | | | |
| We have different ideas about how to demonstrate affection appropriately | | | | |