INTAKE FORM – CONFIDENTIAL

Patient Information: Date: _____

Last Name: _____ First: _____ MI: ___

Date of Birth: _____ Age: _____ Sex: ____ SSN: _____

Mailing Address: _____

City/State: _____ Zip: _____

Home Phone: (___) _____ Work: (___) _____ Marital Status: _____

Name of Person(s) Financially Responsible: _____

Relationship to Patient: _____

Address (if different than patient's): _____

City/State: _____ Zip: _____

Employer/School Information:

Name: _____ Occupation: _____

Address: _____

City/State: _____ Zip: _____

Education/Degrees: _____ Grade: _____

Parent/Spouse's Information:

Name: _____ Phone: (____) _____

Relationship to patient: _____

Employer Name: _____ Work: (____) _____

Address: _____

City/State _____ Zip: _____

***In Case of Emergency, Contact:**

Home: _____ Work: _____ Other: _____

Medical History

Patient Name: _____

Primary Care Physician:

Name of Practice: _____ Dr. _____

Address: _____ Phone: (____) _____

Past Diagnoses (please give the year):

1. _____
2. _____
3. _____

Current Medications (include dosage and frequency):

1. _____ 3. _____
2. _____ 4. _____

Known Allergies: _____

_____

Severe Illnesses (childhood to present):_____

_____

Previous Out/In Patient Therapy (please specify which): _____

_____

Stressors affecting you or your family in the past 1 – 2 years:

____ Deaths	_____ Job Change	_____ Sexual Abuse
____ Births	_____ School	_____ Broken Relationship
____ Marriage	_____ Step-children	_____ Unwanted Pregnancy
____ Divorce	_____ Separation	_____ Substance Abuse
____ Moving	_____ Physical Abuse	_____ Medical
____ Chronic Illness	_____ Other:	

Presenting Problems/Reason for Visit: _____

_____

_____

The Center for Psychological Wellness, PA

Roger B. Moore, Jr., PhD
Clinical and Forensic Psychology

Release of Information

I, _____ , consent to allow Dr. Roger Moore of The Center for Psychological Wellness to release and/or exchange information regarding the patient, _____ .

This information will include:

_____ Procedures
_____ Medical Records
_____ Educational Records
_____ Other _____

_____ Psychological Testing
_____ Therapy Notes
_____ Discharge Summary
_____ All of the above

To/With (Name and Address of Person/Agencies):

_____

_____

_____

_____

I understand that this information will be used in the client's best interests to benefit current psychological evaluation and/or treatment. I understand that the information exchanged will be handled in a professional and confidential manner.

It is the policy of The Center for Psychological Wellness to not release the materials provided by physicians from outside this office regarding the patient's former or current care. You may obtain second party records by contacting the source directly. Second party records will only be released when such records are no longer available from the original source.

I also understand that I may revoke this consent at any time except to the extent that action based on this consent has already taken place. This consent expires in 360 days.

Signature: _____ Witness: _____

Relationship to Patient: _____ Date: _____

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Policies and Procedures

APPOINTMENTS

The keeping of appointments is the most effective means of successful therapy. As schedule permits, we will work with you to find a convenient time for your appointments. Scheduling of appointments constitutes an agreement to pay for the professional time reserved for you. Our policy is to charge appointments missed or cancelled with less than 24 hours of notice at the rate of the reserved session. You will be billed directly for this time. We also charge for telephone and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate should the doctor deem it appropriate.

PAYMENT OF FEES

Payment for services is to be made at the time of the appointment. We accept cash, check and MasterCard or Visa. Unpaid account balances must be paid in full by the close of month. Unpaid balances older than 90 days will be charged an interest rate of 1.5% per month.

Should it become necessary to seek outside help to collect on an account the patient will be responsible for any additional fees or charges and an interest rate of 15%.

The patient is responsible for the provider's fee plus expenses should a court appearance become necessary. There will be a $25.00 charge for all returned checks.

Appointments may be rescheduled until payment is received.

IMPORTANT: Reminder calls and emails to patients are done by our staff as a courtesy. Failure to receive a reminder call or email does not relieve the patient from the responsibility for payment of missed appointments.

REPORTS, CONSULTATIONS AND OTHER CLERICAL DUTIES

Any reports, professional consultations or tasks involving time beyond that of the regular scheduled session will be pro-rated and charged according to the professional or clerical time involved.

PLEASE READ CAREFULLY AND SIGN BELOW: I have read and understand the above statements. I agree to comply fully with the policies of this office. I recognize and accept full financial responsibility for all services rendered.

Patient/Resp. Party Signature _____

Date_____ Witness _____

301-F Keisler Drive, Cary, NC 27518 | phone 919.852.0799 | fax 919.852.0792
rmoore@psychwellness.net | www.psychwellness.net

Revised 8/1/2020

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Acknowledgement of Privacy Practices

Patient Name _____ DOB _____

I understand that a patient's health information is private and confidential. I understand that The Center for Psychological Wellness works hard to protect my privacy and preserve the confidentiality of my health information.

I understand that The Center for Psychological Wellness may use and disclose my personal health information to help provide health care to me, to handle billing and payments, and to take care of other health care operations. In general, there are not other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatens to hurt another person.

This office has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice of Privacy Practices".

Within the Notice of Practices is contained a complete description of my privacy/ confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communications be by specified methods or alternative locations.

The Center for Psychological Wellness has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements information, charges for copies and non-routine information needs, etc. I will assist the office by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of The Center for Psychological Wellness "Notice of Privacy Practices".

_____

Patient or legally authorized individual's signature Date Time

_____

Relationship to patient (if signed by other than the Patient)

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NOTICE OF PRIVACY PRACTICES

The Health Insurance & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used, "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. An example would be an internal quality assessment review.

The use and disclosure without your consent or authorization is allowed under certain sections of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives to other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friend, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- You have the right to restrict certain disclosures of PHI (Protected Health Information) to a health plan when you pay out-of-pocket in full for services.
- You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) a risk assessment fails to determine that there is a low probability that your PHI has been compromised.

We will also obtain an authorization from you before using or disclosing:

- PHI in a way that is not described in this Notice.
- Psychotherapy notes

Private Contract – Provider Opt-Out of Medicare

Physician Name: Dr. Roger B. Moore, Jr., PhD

Provider Address: 301-F Keisler Drive, Cary, NC 27518 Phone Number: 919-852-0799

Beneficiary Name:

Legal Representative (if applicable):

Beneficiary Medicare Number:

This private contract agreement is between the Physician and Beneficiary noted above. The Beneficiary is a Medicare Part B Beneficiary and is seeking services covered under Medicare Part B. The Physician above has informed the Beneficiary or his/her legal representative that the Physician has opted out of the Medicare program. The current Medicare Opt-out period is from _9/28/22_ to _9/28/24_. The Physician noted above is not excluded from participating in Medicare Part B under [1128], [1156], or [1892] of the Social Security Act.

The Beneficiary or his/her legal representative has read and agrees to the following terms of the private contract by placing their initials by the items below:

Initial

____ I, or my legal representative, accept full responsibility for payment of the physician's charge for all services furnished by this physician.

____ I, or my legal representative, understand that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

____ I, or my legal representative, agree not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

____ I, or my legal representative, have been informed of the expected or known expiration date of the opt-out period; which is 9/28/22 to 9/28/24

____ I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

____ I, or my legal representative, enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

____ I, or my legal representative, understand that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

____ I, or my legal representative, acknowledge that I am not currently in an emergency or urgent health care situation.

____ I, or my legal representative, acknowledge that a copy of this contract has been made available to me.

_____

Beneficiary or his/her legal representative Date

_____

Dr. Roger B. Moore, Jr., PhD Date

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Telehealth Communications

During the COVID-19 national public health emergency (PHE), regulatory actions allowed for changes to many aspects of health care delivery to mitigate the risk of spreading the virus. Health care providers subject to HIPAA rules were given broad leeway to communicate with patients and to provide telehealth services through various remote audio or video communications technologies. Some of these technologies and the manner in which they have been used may not fully comply with the requirements of HIPAA rules now that the PHE declaration has expired.

Though some of the telehealth flexibilities will remain in effect until December 2024, we strongly advise all clients to use HIPAA-compliant means when communicating with us, such as the TherapyAppointment patient portal, or for telehealth sessions – Zoom. These technology vendors have HIPAA business associate agreements (BAAs) with us in connection with the provision of their services to protect the privacy and security of your health information.

If you choose to use any other means of communication—technology, software, applications, or devices—that are not HIPAA-compliant, you do so with the understanding that these methods potentially introduce privacy risks even if encryption and privacy modes are enabled. If you initiate contact by emails, text messages, phone, or video chat applications, you authorize us to correspond with you by that same method. You acknowledge and agree that Dr. Moore and The Center for Psychological Wellness have no liability for any breach of privacy resulting from your communications with us by other than the TherapyAppointment patient portal or by Zoom.

Name _____

Signature _____ Date _____

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Critical Information for Medicare/Medicaid Patients

I, _____ , understand that Dr. Roger B. Moore, Jr. and The Center for Psychological Wellness are not Preferred Providers under Medicare and Medicaid. I understand I am responsible for payment at the time of my visit and that I agree not to file for reimbursement of these visits to Medicare and/or Medicaid.

Print Name _____ Date _____

Signature _____

Witness _____

NOTE: ALL PLANS ARE DIFFERENT, SO PLEASE CALL THE NUMBER ON THE BACK OF YOUR HEALTH INSURANCE CARD FOR MORE DETAILED INFORMATION REGARDING YOUR PLAN.

Signature: _____ Date: _____

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