"Your Bridge over Troubled Waters"

Welcome and thank you for choosing LifeBridge, Inc.! We are honored you chose us to help you with your personal concerns. We respect the notion that reaching out to a therapist can be intimidating and sometimes scary. We want you to know that our professional providers are here to listen and provide support during this time. Each therapist seeks to meet their client right where they are and help them on their individual journey to where they want to be. With the upmost respect, compassion and dignity, we your Bridge over help to become your best version of you and your authentic self. At LifeBride,Inc., we realize that everyone get stuck at some point in life and we want to be "Your Bridge Over Troubled Waters" to get you to the other side.

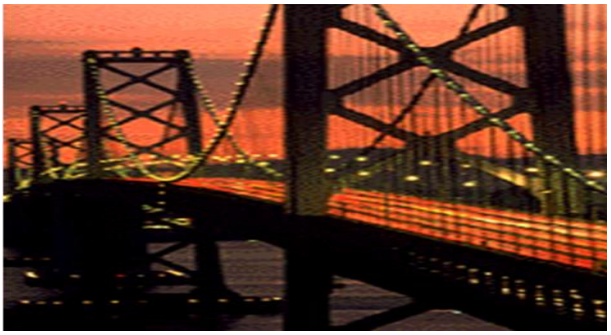
Instructions:

- Verify your mental health benefits with your insurance carrier before arriving to your first appointment. Insurance has become more complicated and sometimes your mental health benefits are managed by a different carrier than your medical. In these cases, your Out of Network benefits will apply. At LifeBridge, Inc., we provide our clients using Out of Network coverage with a bill to submit to their insurance carrier for reimbursement from the insurance company. We want to help you make the most out of your insurance benefits so here is an important tip for when you call your insurance carrier:

    - ❖ TIP - Ask about your In and Out of Network benefit coverage for Psychotherapy sessions with a Professional Mental/Behavioral Health or Substance Abuse Counselor in an Outpatient Office Setting. No specific code is needed. Specify sessions are in a office (not a facility).

- Please complete each section of the Intake packet attached and provide all required signatures and print one sided copies. Note: Cut off pages or signature lines on the following page cannot be accepted.

To ensue you get the most out of your time with your counselor, please arrive 30 minutes prior to the appointment time to allow for processing of your intake paperwork. This will allow your full appointment to be used with your counselor.



WELCOME!

ALL INFORMATION IS REQUIRED; PLEASE DO NOT SKIP. THANK YOU FOR CHOOSING LIFEBRIDGE, INC.

PRINT CLIENT NAME: _____ DATE: _____
FIRST MIDDLE LAST

Preferred name: _____ Date of Birth ____ / ____ / _____ Age _____

Address _____City _____ Zip Code _____

Phones: Mobile _____-_____-_____ Home _____-_____-_____ Work _____-_____-_____
-

Preferred Phone: Mobile ☐ Home ☐ Work ☐ Messages OK? Yes ☐ No ☐

Email: _____ Male ☐ Female ☐
(PLEASE PRINT, MUST BE LEGIBLE FOR APPT REMINDERS)

Married ☐ Single ☐ Employed ☐ Unemployed/Other ☐

Ethnicity: African American ☐ Asian ☐ Caucasian ☐ Latino ☐ Native American ☐ Other ☐

PERSON RESPONSIBLE FOR BILLING: *If Client is responsible for billing, provide Company Name and check "Self"

Name: _____ Employer: _____

Relationship: Self ☐ Spouse ☐ Mother ☐ Father ☐ Step-Parent ☐ Guardian ☐

Other (Describe): _____ Date of Birth: _____ / _____ /_____

Address (if different) _____City _____ Zip Code _____

Phones: Mobile _____-_____-_____ Home _____-_____-_____ Work _____-_____-_____

Email: _____ Use for appt. reminder also: Yes ☐ No ☐

IN CASE OF AN EMERGENCY CONTACT (required):

☐ Check if this contact is the same as "Person Responsible for Billing", otherwise complete below.

Name: _____ Relationship to client: _____

Phones: Mobile _____-_____-_____ Home _____-_____-_____ Work _____-_____-_____

Authorization to Release Information: I Agree ☐ I Decline ☐

PRIMARY CARE PHYSICIAN (PCP):

PCP Name: _____Company/Group Name: _____

City: _____ Phone: _____-_____-_____ Fax: _____-_____

Authorization to Release Information to PCP: I Agree ☐ I Decline ☐ None - N/A ☐

HOUSEHOLD MEMBERS (other than self):

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Have any immediate family members deceased? No ☐ Yes ☐

Health Inventory

Please circle any area of concern for yourself/client:

Alcohol or Drug Use	Gambling	Panic
Alcohol or Drug Use in family	Feelings of Guilt	Poor Concentration
Anger/ Irritability	Grief/Loss	Stress
Anxiety	Impaired Memory	Sexual Problems
Childhood Abuse or Neglect	Less Interest or Pleasure in Things	Self Esteem
Depression	Mood Changes	Sexual Assault/Rape
Difficulty Making Decisions	Muscle Tension	Sleeping Problems
Domestic Violence	Menopause	Thoughts of Suicide/Death
Excessive Worry	Nervousness	Thoughts of Homicide
Finances	Pain	Weight Loss/Gain

Have you/client ever abused alcohol or drugs? No ☐ Yes ☐ Parents: No ☐ Yes ☐

If yes, please explain: _____

Do you or does any family member suffer from alcoholism, addiction or mental disorders? No☐ Yes☐

If yes, please explain:_____

Have you/client ever experienced or witnessed a traumatic event/s? No ☐ Yes ☐

If yes, please explain: _____

_____

_____

Health History

Please circle if you or client (if minor) has ever been treated for any of the following:

Allergies	Diabetes	High Blood Pressure
Asthma	Emotional Disorder	HIV/Aids
Arthritis	Seizure Disorder	Low Blood Sugar
Back Pain	Stomach Disorder	Cancer
Headaches	Pain	Head/Brain Injury
Hearing Problems	Skin Problems	Heart Disease

Please list any known health issues or disabilities:

_____

Are you currently under the care of a physician or psychiatrist for any physical or emotional condition?

No ☐ Yes ☐ If yes, please provide physician name:_____

Reason Seeking Treatment: _____

Prior Counseling Information:

Name of Clinician	Year and Length of Treatment

Please list all current medications:

_____

Previous hospitalizations (date/reason):

_____

Personal History

Reason you/client is seeking counseling?

_____

_____

How would you rate the seriousness of your / client's current condition?

0	1	2	3	4	5	6	7	8	9	10
Not Very		Slight			Moderate			Serious		Extremely

What specific behaviors, actions, feelings or habits would you /client like to change about yourself?

_____

_____

What are some of your special talents or skills that you feel proud of?

_____

_____

Please describe your social functioning/social life.

_____

_____

Are you/client currently involved in any litigation? No Yes

If yes, please explain:

_____

_____

What are your goals for counseling?

_____

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Additional Notes:

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By signing, I agree the above information is true, to the best of my knowledge.

_____ _____

*CLIENT/GUARDIAN'S SIGNATURE DATE

HIPAA Authorization Form

PLEASE COMPLETE IF YOU WISH TO SHARE ANY CLIENT INFORMATION

OR

DECLINE AT BOTTOM OF PAGE

AUTHORIZE:

LifeBridge, Inc. has taken measures to protect all of our clients' private health information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices. HIPAA (Health Insurance Privacy & Accountability Act) does not allow us to release any information to outside entities on your behalf without your written consent.

I am authorizing the person(s) listed below to obtain HIPAA information about myself. I understand that LifeBridge, Inc. is not responsible for the information provided as long as it is given to the person/people that I have listed below. I understand that I may revoke this authorization in writing at any time.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

1. Name: _____ Date of Birth: _____ Relationship: _____

2. Name: _____ Date of Birth: _____ Relationship: _____

3. Name: _____ Date of Birth: _____ Relationship: _____

4. Name: _____ Date of Birth: _____ Relationship: _____

OR

DECLINE:

☐ I do not authorize LifeBridge, Inc. to release any of my protected health information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

_____ _____

***CLIENT/GUARDIAN'S SIGNATURE** **DATE**

INSURANCE / PAYER INFORMATION FORM

CLIENT NAME: _____ DOB: ____ /____ /_____
(FIRST) (MIDDLE) (LAST)

IS THIS CLIENT COVERED BY INSURANCE? YES ☐ NO ☐

- IS LIFEBRIDGE, INC. IN NETWORK WITH YOUR INSURANCE? YES ☐ NO ☐
- IF YES: COMPLETE APPLICABLE INSURANCE INFORMATION SECTION BELOW.
- IF NO: CHECK: SELF PAY ☐ and PROVIDE PREVIOUSLY AGREED UPON RATE: $_____

Note: LIFEBRIDGE, INC. does not file Out of Network claims. We will provide you with a Super Bill. You may use this bill to file with your insurance for possible OON benefits.

EAP: GROUP: _____ CERT #: _____ # OF SESSIONS: _____

***IMPORTANT: PLEASE PROVIDE THE PRIMARY INSURANCE INFORMATION BELOW (AND A COPY OF INSURANCE CARD), FOR SERVICES RENDERED AFTER THE EAP SESSIONS ARE COMPLETE. NOTE: EAP CERTIFICATION FORMS MUST BE RECEIVED IN OUR OFFICE BEFORE SERVICES ARE RENDERED IN ORDER TO BE BILLED. OTHERWISE, THE PRIVATE INSURANCE WILL BE BILLED.**

Do Not Leave Blank

INSURANCE COMPANY NAME:_____
For your Mental Health/Behavioral Health/SA Coverage

MEMBER ID #: _____ GROUP #: _____

DEDUCTIBLE DUE: $ _____ CO-PAYMENT: $ _____ COINSUR %: _____

Other Insurance Info:_____

PRIMARY POLICY HOLDER: X Check if self (client), otherwise complete below.

PRIMARY SUBSCRIBER NAME: _____ DOB: ____ /____ /_____
(FIRST) (MIDDLE) (LAST)

ADDRESS: _____ _____
(STREET) (CITY) (STATE) (ZIP CODE)

HOME PHONE #: _____-_____-_____ CELL PHONE #:_____-_____-_____

EMPLOYER:_____ RELATIONSHIP TO CLIENT:_____

LIFEBRIDGE, INC. FINANCIAL SERVICES AGREEMENT

*FINANCIAL AGREEMENTS ARE THE COMPANY POLICIES OF LIFEBRIDGE, INC. IN ORDER TO MAINTAIN A THERAPEUTIC ENVIRONMENT, COUNSELORS ARE ASKED TO NOT ADDRESS THESE POLICIES. IF YOU HAVE ANY BILLING OR INSURANCE QUESTIONS OR CONCERNS, PLEASE DIRECT THEM TO THE APPROPRIATE OFFICE STAFF.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment, directly to LifeBridge, Inc., of insurance benefits for provided services otherwise payable to me. *If I will not be using in-network insurance benefits, self-pay arrangements must be made in advance. All information below still applies, including pro bono cases.

RESPONSIBILITY FOR PAYMENT: I agree that I am responsible for the total balance due on my account for services rendered by LifeBridge, Inc. It is my responsibility to understand my insurance policy benefits and coverage. If I have any questions, I agree to contact my insurance company before services are rendered. It is my responsibility to inform LifeBridge, Inc. of my current address, phone number, insurance information and any change to my credit card information until my final balance is paid in full.
*Insurance inquiry tip: For our most common routine therapy sessions, call your insurance company and request benefits coverage information for “professional psychotherapy visits in an office (place of service) setting.”

PAYMENTS (CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLE): Payments are due in full at the time service is rendered. Cash, Check, or Credit Card will be accepted. LifeBridge, Inc. does not get involved in dividing charges among multiple parties. *Minor clients: Payments must be made at the time of service by whomever brings the client to the appointment.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Since I will be reserving appointment times in advance at LifeBridge, Inc., I agree to pay a $75 fee for any scheduled appointment that I either miss or cancel with less than a prior 24 business hour notice (M-F, 9-5). *Clients utilizing aid funding or sliding scale rates will be charged their standard fee if under $50.00. See detailed missed appointment policy provided to you for your records. Pro bono cases may lose this privilege.

COURT FEES: If my presence is required in court, a fee of $175.00 per hour (with a 1-hour minimum charge) and an automatic 1-hour prep session fee is payable prior to the court date ($350.00 retainer deposit). This includes my physical presence and standby phone testimony.

MEDICAL RECORDS FEE: Fee for a personal copy of medical records is $35.00. Fee for an attorney or other third party requests for medical records is a min. of $10.00. Additional fees are calculated per page as set by state standards. Fees are due before records will be provided.

SECURITY ARRANGEMENT: It is the policy of LifeBridge, Inc. to obtain security in the form of your credit card authorization to conveniently pay for possible charges that will not be covered by your insurance carrier. These possible charges include unanticipated missed appointments, late cancellations, charges for insufficient funds for checks or credit card payments, unmet deductibles, and insurance company UCR discrepancies from the actual fees. For your convenience, cc information may be stored and used for payments at time of service (co-pay, co-insurance, etc.). All credit card information will be stored securely and confidentially as part of the medical record protected by HIPAA. *This service is helpful for parents with teens as clients.

Full Name on card (print): _____ Zip Code: _____

Card Number: _____ _____ _____ Expiration Date: _____ / _____ Circle: VISA / MC

I HAVE READ AND AGREE TO THE ABOVE FINANCIAL AGREEMENT POLICIES:

_____ _____

***CLIENT/GUARDIAN’S SIGNATURE** **DATE**

Client’s Copy

CLIENT'S RIGHTS and RESPONSIBILITIES

LifeBridge, Inc. provides services to clients on a nondiscriminatory basis without regard to gender, age, race, national origin, cultural background, religion, sexual orientation, disability, marital status or financial resources. We appreciate the opportunity to serve as your behavioral healthcare provider.

CLIENT'S RIGHTS: As a client, you are entitled to certain rights to protect your dignity, privacy and individuality. They are summarized and guaranteed as follows:

- You have a right to access needed behavioral health services and a right to consent to or refuse treatment.
- You have a right to have the treatment of this group including access to medical care and habilitation without regard to age, race, color, creed, national origin, beliefs, values, mh/dd/sa disability, sex, sexual preference, handicap or source of payment.
- You have the right to expect humane and considerate treatment with respect for your personal dignity and privacy.
- You have the right to freedom from physical or mental abuse or harm.
- You are entitled to receive services in accordance with a specialized treatment plan designed to meet your needs.
- You can expect to participate in the planning of your treatment.
- You may obtain a copy of your treatment plan by verbally requesting it from your clinician.
- You are entitled to complete and current information concerning your diagnosis, treatment plan and progress in terms you can understand. You have a right to participate in decisions affecting your care.
- You have a right to authorize the release/disclosure of private information and know the release of this information may only occur with your written consent.
- You have the right to receive information about fees and payments for services as well as explanation of your bill regardless of how it is to be paid.
- You have the right to expect your personal privacy to be respected and all communications and records pertaining to your care to be kept confidential. Exceptions: 1) Privacy is waived by client or legal representative, 2) Disclosure is required to prevent imminent danger to yourself or others.
- You have the right to contact Disability Rights of NC (formerly Governor's Advocacy Council for Persons with Disabilities).

CLIENT'S RESPONSIBILITIES: As a client, you also have certain responsibilities as outlined below.

- To treat others with courtesy and respect while respecting the privacy of others.
- To participate in treatment planning.
- To attend all appointments or give proper notice of cancellation.
- To pay fees that you have agreed to pay.
- To respect the staff and property of LifeBridge, Inc..
- To not bring illicit drugs or alcohol to a LifeBridge, Inc. facility.
- To not share medication with any other individual.
- To not bring weapons of any kind to any LifeBridge, Inc. facility.
- To not behave in a violent or threatening manner.
- To monitor children at all times.
- To agree to maintain a smoke free environment.
- To read and abide by the posted office rules and notices.
- To keep LifeBridge, Inc. up to date on changes of contact and/or insurance information.

_____ _____

***CLIENT/GUARDIAN'S SIGNATURE** **DATE**

LIFEBRIDGE, INC. MISSED APPOINTMENT POLICY

A "missed appointment" fee is not a "fee or charge for a service rendered by the provider," but rather a fee for a "missed business opportunity" by the provider and company. Neither a private nor government insurance agency will pay this fee for the client. It is the sole responsibility of the client. The Centers for Medicare and Medicaid (CMS) Chapter 12, section 30.3.13 allows providers to charge a fee for missed appointments provided they do not discriminate and charge all such clients the same.

Policy: Missed appointments are disruptive to the clinical relationship as well as to the clinician's schedule. The clinical relationship is best provided in a context of consistency and stability. The best care is provided and the best treatment plan progress is made when the clinician and client are dedicated to the process.

A "missed appointment" fee will automatically be applied to your account by our software program whenever a client fails to be present at the scheduled appointment time, or when the scheduled appointment is cancelled (or rescheduled) with less than a "full 24 business hour notice" of the booked appointment time. This fee should be paid no later than the next scheduled appointment. If no further appointment is scheduled, the fee is due on the date of the missed appointment. The missed appointment and reason for the missed appointment will become part of the client's medical record.

In order for appointments to be cancelled and/or rescheduled without incurring a fee, the client may contact our front office at least "24 business hours" before the scheduled appt. at 919-307-6551, M-F from 9-5. Please contact your counselor for changes needed for appointments made before and after normal business hours (including Saturdays).

We understand emergencies and acute illnesses do sometimes occur, and you are unable to meet the policy criteria for missed appointments. We will be happy to work with these cases. Please provide the front desk with the emergency reason, and it will be reviewed with your counselor. Please note the following are not recognized as emergencies: 1) Conflicts with other scheduled appointments (other physician, work, school, vacation, etc.), 2) Injury or illness occurring greater than 24 hours before appt., 3) Child care not available, 4) Transportation not available.

Fee: $75.00
Client Aid / Sliding Scale: Clients utilizing sliding scale rates will be charged their standard fee for services.

Chronic Missed Appointments: LifeBridge, Inc. or your therapist may decide to terminate services for multiple missed appointments.

Reminder: LifeBridge, Inc. provides an automated email reminder 48 hours before the scheduled appointment time.

_____ _____

***CLIENT/GUARDIAN'S SIGNATURE** **DATE**

Client's Copy

LIFEBRIDGE, INC.
NOTICE OF HEALTH INFORMATION PRIVACY ACT

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a therapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by Health Insurance Portability and Accountability Act (HIPAA) and/or North Carolina Law. However, in the following situations, no authorization is required:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. These other professionals are also legally bound to keep the information confidential. Unless you object, we will only tell you about these consultations if we feel that it is important to our work together. All consultations will be noted in your Clinical Record (which is called "PHI" in our Notice of Policies and Practices to Protect the Privacy of Your Health Information).

- We practice with other mental health professionals, and we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All administrative staff have been given training regarding protecting your privacy and have agreed to not release any information outside of the practice without the permission of a professional staff member.

- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. You have the right to restrict the disclosure of PHI to your insurance company if you pay for services in full.

- We may use or disclose your health information for our normal health care operations. For example, one of our staff members will enter your information into our computer. Use and disclosure of your PHI for marketing purposes and the sale of PHI is not allowed without your written authorization.

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. We cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against us, state law permits us to disclose relevant information regarding that patient in order to defend ourselves.

There are some situations in which we are legally obligated to take actions that we believe are necessary to protect others from harm and in which we may have to reveal some information about a patient's treatment. These situations are unusual in our practice, but they include:

- If we have reason to suspect that a child or vulnerable adult has been subjected to abuse or neglect or that a vulnerable adult has been subjected to self-neglect or exploitation, the law requires that we file a report with the appropriate government agency, which is typically the local office of the Department of Social Services. Once such a report is filed, we may be required to provide additional information.

- If we know that a patient has a propensity for violence and the patient indicates that he/she has the intention to inflict imminent physical injury upon a specified victim(s), we may be required to take

protective actions. These actions may include establishing and undertaking a treatment plan targeted to eliminate the possibility that the patient will carry out the threat, seeking hospitalization of the patient, and/or informing the potential victim or the police of the threat.

- ❖ If we believe that there is an imminent risk that a patient will engage in potentially life-threatening behaviors or that immediate disclosure is required to provide for the patient's emergency health care needs, we may be required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action, and we will limit the disclosure to what is necessary.

While this written summary of exceptions to confidentiality aims to inform you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex and we, in situations where specific guidance is required, may need to seek formal legal advice.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep protected health information about you in your clinical record. You may examine and/or receive a copy of your clinical record if you request it in writing. In unusual circumstances in which disclosure is reasonably likely to endanger the life or physical safety of you or another person, we may refuse your request. In those situations, you have a right to a summary and to have your record sent to another mental health provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence or have them forwarded to another mental health professional in order for you to discuss the contents. In most circumstances, the State of North Carolina permits a copying fee and certain other expenses. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regards to your clinical records and disclosures of protected health information. These rights include: requesting that we amend your record; requesting restrictions on what information from your clinical records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this agreement, the attached notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you. For more information, you can also visit http://www.hhs.gov/ocr/privacy/index.html.

MINORS & PARENTS

It is important for patients under 18 years of age who are not emancipated and their parents to be aware that the law may allow parents to examine their child's treatment records. However, because privacy in psychotherapy is very important, particularly with teenagers, we usually ask parents to respect the child's privacy and allow for the therapist and minor to keep elements of their interactions in confidence other than any related to danger to the child (see Limits on Confidentiality). On the other hand, because parental involvement in therapy is essential to successful treatment, we are always willing to share with parents general information about the
progress of treatment and their child's attendance at scheduled sessions. Parents may also request an oral summary of their child's treatment when it is complete. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

_____ _____

***CLIENT/GUARDIAN'S SIGNATURE** **DATE**

Client's Copy