Welcome to Anchor Psychological! Below is helpful information for your first appointment.

Patient Portal-Clients will be sent an email to set up a patient portal. Please use the link in your email to set up the account. This portal can be accessed through our website www.anchorpsychological.com under the portal tab for future logins. Portal accounts can be set up through email or an access number. Email accounts must be verified before they are able to be used by the staff at Anchor Psychological. Upon the setup, the front staff will get a message to verify your account.

Directions for Completing Patient Package:

1. Complete administrative forms attached.

2. Complete Professional Disclosure form from therapist who you are scheduled to see (this can be found on the patient portal)

3. Optional-complete the clinical form sent through the portal.

As part of the evaluation process, we collect background information. You will be sent a link through your patient portal to complete this background clinical information. This is optional, but helps your therapist to understand more about you and your past experiences in treatment and your symptoms.

ANCHOR
PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

PATIENT INFORMATION

PERSONAL INFORMATION

LEGAL NAME: _____ **SEX**: M____F____
PREFERED NAME:_____

DOB:_____**AGE**:_____ **SSN**: _____

PHYSICAL ADDRESS: **MAILING ADDRESS**:

_____ _____
_____ _____
_____ _____

Phone Numbers:
Home #_____
WORK #:_____
Mobile #:_____
Email Address:_____(to be used for patient portal set-up)

Phone, Text, Email Reminder for Appointments:_____

MARITAL STATUS: M S W D RACE:_____

STUDENT: Y N **NAME OF SCHOOL**:_____

EMPLOYER NAME & ADDRESS:
_____
_____
_____

Emergency Contact:_____**Phone**:_____ **Relationship**_____

INSURANCE

PRIMARY INSURANCE INFORMATION:
INSURANCE COMPANY NAME: _____
ID#:_____GROUP #:_____
NAME OF SUBSCRIBER: _____
RELATIONSHIP TO PATIENT: PARENT SPOUSE OTHER
SUBSCRIBER SOCIAL: _____DOB:_____

SECONDARY INSURANCE INFORMATION:
INSURANCE COMPANY NAME: _____
ID#:_____GROUP #:_____
NAME OF SUBSCRIBER: _____
RELATIONSHIP TO PATIENT: PARENT SPOUSE SELF OTHER
SUBSCRIBER SOCIAL: _____DOB:_____

ALL CLIENTS: **ASSIGNMENT OF INSURANCE BENEFITS**. I hereby assign all medical and/or therapy benefits, to include major medical benefits to which I am entitled, Private insurance, Tricare, Medicare, and any other health plans to Anchor Psychological & Counseling Services, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim and secure payment for services rendered. If "other health insurance" is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accepts the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, co-Insurance and any non-covered services. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. Please be advised that the contract with health insurance companies requires that Anchor provide it with information relevant to the services that are provided to you. Anchor is required to provide a clinical diagnosis. Sometimes Anchor is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this Agreement, you agree that I can provide requested information to your carrier if deemed necessary.

Signature:_____Date:_____

If you have a supplemental policy and is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the Benefits payable for related services.
SIGNATURE AS IT APPEARS ON MEDIGAP CARD: _____DATE:_____

RESPONSIBLE PARTY:

[ ] Please check here if the patient is the responsible party

For Children or Clients with Guardians, please specify information on both parents and indicate who is responsible for payment. (Note: Ultimately, the person who signs the paperwork is responsible if the parties do not agree unless a court order is shown).

PARENT/GUARDIAN (MOTHER):
NAME: _____SEX: M F
SSN: _____DOB:_____AGE:_____
ADDRESS: _____
_____
Phone: (H)_____(M)_____(W)_____
Email Address:_____

MARITAL STATUS: M S D W
RELATIONSHIP TO PATIENT (CIRCLE ONE): PARENT GUARDIAN
IS THIS PARENT/GUARDIAN RESPONSIBLE FOR PAYMENT? Y N (Circle one)

PARENT/GUARDIAN (FATHER):
NAME: _____SEX: M F
SSN: _____DOB:_____AGE:_____
ADDRESS: _____
_____
Phone: _____
MARITAL STATUS: M S D W
RELATIONSHIP TO PATIENT (CIRCLE ONE): PARENT GUARDIAN
IS THIS PARENT/GUARDIAN RESPONSIBLE FOR PAYMENT? Y N (Circle one)

Please Indicate any specific custody arrangements or guardian information.

_____

_____

Do you want anyone to be able to schedule or cancel appointments for you?
(circle one) Yes No
Who?

Name:_____ Phone #:_____Relationship:_____

PRIVACY/CONFIDENTIALITY:

I HAVE READ, UNDERSTAND, AND AGREE TO THE HIPPA PRIVACY GUIDELINES, THE CLIENT BILL OF RIGHTS, THE OFFICE PROCEDURES AND FINANCIAL POLICY, THE RIGHTS AND CONSENT TO TREAT, AND THE LIMITS OF CONFIDENTIALITY. I HAVE CONSENTED TO ANCHOR PSYCHOLOGICAL BILLING MY INSURANCE COMPANY AND UNDERSTAND THAT THE RESPONSIBLE PARTY IS RESPONSIBLE FOR ANYTHING NOT COVERED UNDER INSURANCE.

_____ _____

Name of Client Name of Responsible Party

_____ _____

Signature of Responsible Party Date

PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

Office Procedures & Financial Policy

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing that you have read the Office Procedures & Financial Policy, you are agreeing to be bound by these terms.

APPOINTMENTS

MISSED APPOINTMENTS: In fairness to other patients and the Therapist, **we require at least 24 hours notice and one business day to cancel an appointment.** (i.e., Appointments scheduled for Monday must be canceled no later than Friday). You may be charged $50.00 for each appointment that was missed or not canceled with 24 hour notice. Missing more than two appointments without providing 24 hours notice is grounds for discharge from the practice. 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.

INSURANCE

FOR PATIENTS WITH MEDICARE: We will bill Medicare on your behalf. As a courtesy, we will also bill secondary insurance carriers on your behalf. You are responsible for all co-insurance payments.

FOR PATIENTS WITH INSURANCE: All co-payments and deductibles are due at the time of services. We will bill insurance carriers on your behalf if we have a current contract with the carrier. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable from you. Our office will always strive to help you obtain the maximum possible coverage. It is, however, the patient's ultimate responsibility to determine the extent of coverage allowed by the insurance company.

In addition, preauthorization of a procedure is not a guarantee for payment. Any procedure may be considered not covered under the terms of your agreement with your insurance company. Your insurance carrier will make a determination of payment once the claim is received and reviewed. If after the claim is reviewed and it is determined by your insurance company that the procedure is **not** covered you will be financially responsible to Anchor Psychological & counseling Services, PLLC for the charges and will be billed for those services not covered by your insurance company.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.

FINANCIAL

BASIC POLICY: Payment is due in full at the time service is provided in our office.

RETURNED CHECKS: There will be a fee of $35.00 charged by this office for each check returned to us by your bank.

OUTSTANDING BALANCES: You are responsible for paying any balances due on your account. Once we received the 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 Anchor Psychological 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 discontinuing services. If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services at Anchor Psychological, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with the Office Manager.

COLLECTION AGENCY COSTS: In the event that your account is forwarded to a collection agency, you agree to pay an additional fee equal up to 33% of the balance forwarded to the collection agency for balances under $75 and 40% for balances over $75 and any additional attorney fees or court costs.

ADDITIONAL SERVICES

In some circumstances, depending on the time involved and the nature of task, you may be charged for additional services such as extended sessions, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment.

Phone Calls: Typically there is no charge for phone calls. However, phone calls that are extended and/or constitute therapy will be billed at the rate of $20/ 15 minutes directly to the client because insurance does not cover this service.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes insurance does not reimburse for testing. In this event, you will be responsible for uncovered testing at the self pay rate. Testing fees are $130 per unit of testing.

Collateral Appointments: (Appointments about a client without the client present, i.e., parents meet with therapist without child). Some insurance companies do not reimburse for appointments when the client is not present. This could result in the client being billed at the self pay rate.

ANCHOR
PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

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 Anchor Psychological 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. The state law also allows for exchange of clinical information with other medical professionals to assist with coordination of care to provide optimal care.
- 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 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 Anchor Psychological clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians at Anchor Psychological are Mary Godin, MA, LPA, LPC, Shawn Morton, M. Ed., NCC, LPC, RPT, Alexis Steele, MSW, LCSW, Jennifer Gilman MSW, LCSW, Kim Johnson, MA, LMFT, Kimberly Giddo, M.Ed., Ed.S, LPC, NCC, Jeanna M. Lloyd, MSW, LCSW-C
- I understand that my therapist may 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 their licensure or certification.

I have read and understand this document and will address any concerns or questions with my therapist and/or the office manager.

PATIENT QUESTIONNAIRE

REASON FOR VISIT:

CURRENT ISSUES (Check all that apply to you)

_____ Depression
_____ Stress
_____ Anxiety
_____ Attention Problems
_____ Self Confidence/Self Esteem
_____ Anger Management
_____ Sexual Abuse/Molestation
_____ Sexual Assault
_____ Hyperactivity
_____ Impulsivity
_____ Grief/Loss
_____ Pregnancy (Past, present)
_____ Learning Disability
_____ Academic
_____ Body Image
_____ Eating Disorder/Eating Issues
_____ Drug/Alcohol Abuse
_____ Physical Abuse
_____ Sexual Identity Issues
_____ Racial/Cultural Issues
_____ Physical Health
_____ Decision Making
_____ Financial Problems
_____ Delusions
_____ Hallucinations
_____ Suicidal Feelings
_____ Loneliness Isolation
_____ Military Related Problems
_____ Reintegration
_____ Flashbacks
_____ Nightmares
_____ Sleep Problems
_____ Legal Problems
_____ Romantic Relationships
_____ Family Relationships
_____ Divorce/Separation
_____ Mania
_____ Homicidal Feelings
_____ Fears/Phobias
_____ Neglect

ADDITIONAL CLARIFICATION FOR VISIT:_____
_____

WHO IS YOUR PRIMARY CARE DOCTOR/CLINIC?_____

PLEASE LIST ALL OF MEDICATIONS WITH DOSAGES, INCLUDING SUPPLIMENTS:

PLEASE LIST ANY ALLERGIES: _____

HOW DID YOU HEAR ABOUT THIS PRACTICE? (CIRCLE ONE) PSYCHIATRIST_____ OTHER CLINICIAN_____
ANCHOR WEBSITE FRIEND_____ PRIMARY CARE DOCTOR _____ CAPE FEAR PSYCH ASSOCIATION
PREVIOUS CLIENT OF ANCHOR_____ PHONE BOOK CHAMBER PSYCHOLOGY TODAY

PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

It is important for your doctor to have all of your medical information to ensure that you receive the best care possible. The purpose of sending the health information to your doctor is to assist in identifying any follow-up medical care that may be needed. Please allow us to send your health information to your doctor by signing the release of information below. We will only send information that pertains to your care.

Client Name:_____ DOB:_____ DATE:_____

PURPOSE OF RELEASE:_____

MUTUAL EXCHANGE OF INFORMATION

Anchor Psychological and Counseling Services, PLLC
16581 Highway 17, Suite 600
Hampstead, NC 28443
Phone: (910) 270-9995 Fax: (910) 270-9905

AND

Mr/Ms/Dr. _____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

INITIAL appropriate information to be released:

_____Full Clinical Information Record with Substance Abuse
_____Full Clinical Health Information Record Excluding Substance Abuse
_____Psychological Evaluation
_____Verbal Communication
_____Other_____
_____Medical Records
_____School Records

NOTICE OF RIGHTS AND OTHER INFORMATION

Complete your acknowledgement that you understand that:

- You have the right to review the information that is being used or disclosed
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws
- You have a right to revoke this authorization at any time

- You have a right to receive a copy of this signed authorization.

Notice: *This information has been disclosed to you from records protected by the Federal Confidentiality Rules (42 CFR, Part 2). The Federal rules prohibit your from making any further disclosure of this information unless, further disclosure is expressly authorization for the release of the medical or other information is NOT sufficient for this purpose. The Federal Rules Restrict any use of the information of criminally investigates or prosecute any alcohol or drug abuse patient.*

Permission/authorization to release this information expires one year from the date below.

Patient Signature: _____ Date:_____ Time:_____

Signature Guardian/Parent/Authorized Representative: _____