640 Holly Ave
Winston-Salem, North Carolina 27101
Phone (336) 725-3999
Fax: (336) 725-7720
E-mail: trinitycenterinc@gmail.com

MINOR CLIENT INFORMATION SHEET

Client Name: ____ Date: ____________________
Last First Middle Preferred

Date of Birth: ______________________________ Age: ___________

Street Address: ____ Apt. #: ________________

City & State: ______________________________ Zip Code: ______________ County: __________________

Alternate Mailing Address (if you would prefer mail be sent to a different address than above):

____

Please note that Trinity Center requires a mailing address to send correspondence related to billing and case management.

As a courtesy, Trinity Center provides reminders for future appointments. Please indicate your preference:

_______ Phone call Preferred phone number: ______________________________
_______ Email Preferred email address: ______________________________
_______ Text Message Preferred phone number: ______________________________

By providing an e-mail address, you understand that email and text messaging are not secure forms of communication and confidentiality cannot be guaranteed.

Parent/Guardian Information:

Marital Status: Married: _____ Single: _____ Divorced: _____ Widowed: _____ Separated: ____ Partnered: ______

Name: ____ Relationship to Client: ________________________

Address (if different): ____

City & State: ______________________________ Zip Code: _________________ County: _______________________

Preferred Phone 1: _______________________ Cell, Work, or Home number? (Please circle one) OK to leave msg? Y _____ N _____

Preferred Phone 2: _______________________ Cell, Work, or Home number? (Please circle one) OK to leave msg? Y _____ N _____

Employer: ____

If married, partnered, or co-parenting, please complete the following:

Spouse/Partner/Co-Parent Name: ______________________________ Relationship to Client: _________________________

Address (if different): ____

City & State: ______________________________ Zip Code: _________________ County: _______________________

Preferred Phone: _________________________ Cell, Work, or Home number? (Please circle one)

Employer: ____

Continued on back →

Client's Siblings or Others Living in the Household (Name, Age, Relationship to Client)

____ ____

____ ____

<u>Additional Information:</u>

Were you referred by someone? _______ If yes, by whom? ____

If no, how did you learn about Trinity Center? ____

Briefly state the reason for your visit: ____

____

Name of Child's Physician/Medical Practice: ____

Please list Current Medications and Dosages: ____

____

Has your child ever received counseling at Trinity Center before? Please circle: Yes or No Year ____________________

Has your child ever received counseling outside of Trinity Center? If so, please list below:

Name of Counselor Date Last Seen How long was your child in counseling?

____

____

Emergency Contact/Relationship: ____ **Phone:** __________________________

Parent/Guardian Signature: ____Date: __________________________

Parent/Guardian Name (please print): ____

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Informed Consent

Trinity Center, Inc., is a non-profit, tax-exempt organization established to provide counseling, spiritual direction, and education. We are committed to creating a safe, welcoming and affirming environment for all. We recognize each individual as unique, and we value diversity as encompassing intersecting identities including ethnic/racial identity, nationality, sex, gender identity, sexual orientation, religion/spirituality, socioeconomic status, age, body shape/size, ability and point of view.

INITIAL APPOINTMENT

Your first appointment at Trinity Center will be for an intake session. At this time, you will meet with a counselor whose credentials will be provided to you. During the intake session, the counselor's role is to listen to you and help you define your goals for treatment as well as to gather information about you including your history and your current concerns.

After your intake session, we will determine which of our professionals is best suited to work with you. The counselor you see for your initial session may or may not be the counselor assigned to work with you. If it is determined that your needs would be best served outside of Trinity Center, you will be informed of this and appropriate referrals will be given to you.

Once you are assigned to a counselor, you will be called to schedule an appointment. If you are assigned to a Trinity Center counselor different from the intake counselor, you will be given information that describes your assigned counselor's training and areas of expertise at your first appointment with him/her.

THE COUNSELING PROCESS

The purpose of counseling is to create positive change so that you can experience your life more fully. Counseling provides an opportunity to better and more deeply understand yourself and to develop more effective ways of managing and responding to difficulties. You and your counselor will work together to determine your needs and goals for counseling.

In your work here, you may sometimes wonder if progress is being made. It would not be unusual for you to feel sadness, grief, anger or other feelings, which may feel strange or bad to you. Change may also occur in the way you understand yourself and others and consequently, in the way you relate to others. Some of these changes will feel good almost immediately; some of them will not. Please discuss with your counselor any questions you have concerning your goals, treatment, or progress and inform your counselor of the difficulties and successes you are experiencing.

The length and course of counseling will depend on your specific circumstances. Optimally, counseling ends by mutual agreement of you and your counselor. You may choose to discontinue counseling at any time, however you are encouraged to discuss this decision with your counselor. Your counselor reserves the right to discontinue counseling due to non-compliance of treatment recommendations or failure to attend appointments. If your counselor determines that counseling is no longer effective or if your needs warrant more intensive treatment or resources/competencies other than what we can provide, your counselor will provide you with referral information.

COUNSELOR-CLIENT RELATIONSHIP

Ethical practice prohibits dual relationships (i.e., relationships in addition to the therapeutic one) between counselor and client. At the intake interview, please notify us of any relationship you might already have with any of our counseling staff or their families, as this is an important factor in determining which counselor you would be assigned to work with on an on-going basis. Your relationship with your assigned counselor will remain professional throughout the counseling process, precluding the development of personal friendships.

CONFIDENTIALITY

The law protects the privacy of communications between a client and mental health professional. In most situations, Trinity Center can only release information about your treatment to others if you sign a written authorization form. If you participate in marital or family counseling, Trinity Center will not disclose confidential information about your treatment unless all persons who participated in treatment with you provide their written authorization to release such information.

You should be aware that Trinity Center is a practice with many mental health professionals and that Trinity Center employs administrative staff. Your counselor may need to share information about you with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. In keeping with professional standards, counselors may consult with one another for the purpose of providing the best service to you. All of the mental health professionals are bound by the same rules of confidentiality. Everyone who works at Trinity Center has received training about protecting your privacy.

There are legal and ethical exceptions to confidentiality as follows:

- When there is threat of serious harm to yourself or others we may act on your behalf by arranging care or notifying others who can help provide protection. This may include initiating hospitalization, warning a potential victim, contacting family members and/or calling the police.
- If you disclose actual or possible current child abuse or neglect, or the abuse, neglect or exploitation of a disabled adult in need of protection, we must report the information to the appropriate department of social services.
- If we are ordered by a court of law to release information about you, we must do so.

If such a situation arises, your counselor will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary. If you are 17 years old or younger, there are further exceptions to confidentiality which will be discussed with you. Please review the Trinity Center Notice of Privacy Practices carefully for more information related to Protected Health Information.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you and your counselor discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and Trinity Center does not give legal advice. In situations where specific advice is required, formal legal advice may be needed.

COMPLAINTS

If, at any time, you feel your clinician has treated you unfairly or unethically, please discuss this immediately with the clinician. If this does not clarify or resolve the issue for you, please contact Amy Shuman, Executive Director at 336.725.3999. If the matter is still not resolved to your satisfaction, your clinician's licensing board may be of further help to you. If your clinician is a Licensed Professional Counselor, contact the North Carolina Board of Licensed Professional Counselors, PO Box 77819, Greensboro, NC, 27417; 336.217.6007. If your clinician is a psychologist, contact the North Carolina Board of Psychology at 895 State Farm Rd., Suite 101, Boone, NC 28607; 828.262.2258. If your clinician is a Licensed Clinical Social Worker, contact the North Carolina Social Work Certification and Licensure Board, PO Box 1043, Asheboro, NC, 27204; 336.625.1679.

COST AND PAYMENT

A. FEES

The fee for counseling is $140 per session and $72 for spiritual direction.

Payment should be made before each session, including your initial appointment.

B. INSURANCE

Insurance can be filed for counseling only. Spiritual direction is not covered by insurance. You should be aware that insurance plans require a diagnosis of a mental health condition from the Diagnostic and Statistical Manual for Mental Health Disorders (DSM-5) for reimbursement. Some conditions for which people seek counseling do not qualify for reimbursement. If you have questions about a diagnosis, please talk with your counselor. Sometimes insurance companies require additional clinical information such as treatment summaries, progress notes, or a copy of your complete clinical record. Clients who use insurance authorize the release of this information as requested by the insurance company.

Trinity Center is an out of network provider for most insurance companies. If you have out of network insurance, you are responsible for the full fee of $140 at the time of service. You may file claims with your insurance company. **There is no guarantee of benefits with insurance companies**.

C. SUBSIDY FUND

If you do not have health coverage or are otherwise unable to pay the full fee, you can apply to the Betty W. Talbert Client Assistance Fund which receives donations to aid clients for whom counseling or spiritual direction would be impossible without help in paying the fee. Financial assistance is granted according to need and the availability of funds. Client Assistance Fund applications are available at the desk upon request.

Please check one to indicate how you will pay for services:

_______ I will not be using insurance, and I will pay out-of-pocket for any services I receive.

_______ I will be using my in network insurance through BCBS (other than Blue Value), Carolina Behavioral Health Association or Tricare and will be responsible for payment of any fees not covered by insurance.

_______ I have an out-of-network insurance plan and will be responsible for the full fee at the time of service. I would like to receive monthly statements for filing my insurance: yes_____ or no_____.

_______ I am applying to the Betty W. Talbert Client Assistance Fund for help with payment of counseling or spiritual direction.

_______ I have an arrangement with a third party payer (my employer, church or other individual/organization) to pay for my counseling. **I understand that I must sign a release of information form for the third party payer and that I am financially responsible for all charges not paid by the third party payer.**

Name of third party payer: __________________________ Relationship to client: _____________________

Address to be billed: ____

SCHEDULING AND CANCELLATION OF APPOINTMENTS

Available appointment times depend on your assigned counselor. Appointments may be made by phone (336.725.3999) or in person. General office hours are:

Monday through Thursday – 9:00 am to 6:00 pm
Friday – 9:00 am to 12 noon

If you need to cancel or reschedule an appointment, please call at least 24 hours in advance of the appointment time. **Clients will be charged $70 for missed appointments and late cancellations (less than 24-hours' notice).** Clients who receive financial assistance will be charged $70 or their regular session fee, whichever is less. Please note that for Monday appointment cancellations, you will need to call before noon the previous Friday in order to avoid being charged.

Trinity Center provides reminders for clients about their scheduled appointments. Clients may choose to receive these reminders by phone call, email, or text messaging on the Client Information Sheet. Clients who provide their contact information understand that email and text messaging are not secure forms of communication, and Trinity Center cannot guarantee confidentiality. If you need to cancel or reschedule an appointment, please call Trinity Center.

PSYCHOLOGICAL CRISES

If you need to contact your counselor during regular business hours, please call Trinity Center at 336.725.3999. **If you need urgent assistance for a mental health crisis after hours, on the weekend or on holidays, please call 336.671.8777 to reach the Trinity Center counselor on call.** For life threatening emergencies, please dial 911 or go to your nearest emergency department.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO ITS TERMS INCLUDING BEING FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED.

____ ______________________

Signature of Client (or Parent/Guardian if client is a minor) Date

____

Client Name – Please Print

____

Parent/Guardian Name (if client is a minor) – Please Print

640 Holly Ave
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Insurance Information and Release Form

If you plan to use insurance, please complete the following:

Client Name____

Insurance Company____

Subscriber # ______________________________ Group #_________________________

Name of Policy Holder_________________________ Relationship to Client_______________

Address of Policy Holder____

Phone Number of Policy Holder____

Birthdate of Policy Holder ____

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PROVIDER:

In signing below, I express understanding that my insurance coverage is a contract between myself and my insurer. I authorize payment of medical benefits to Trinity Center, Inc. for services rendered, and I accept responsibility for any charges my insurance company does not cover. I also understand that a clinical diagnosis is required by my insurance company for payment and that my insurance company may require additional information such as treatment summaries, progress notes or a copy of my clinical record. By signing this agreement, I authorize the release of clinical or other information requested by my insurer.

____

Signature of Client (or Parent/Guardian if client is under 18) Date

Trinity Center, Inc. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *American Counseling Association Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will post the revised Notice of Privacy Practices on our website and provide a copy to you upon your request.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors, Trinity Center clinicians, and other Trinity Center treatment team members. We may disclose PHI to providers outside Trinity Center only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

Required by Law. We must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a court order, administrative order or similar process.

Serious and Foreseeable Harm. We may disclose your PHI in order to protect you or identified others from serious and foreseeable harm.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel in order to prevent serious harm.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a court order, administrative order or similar document.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Response to Complaint. PHI may be released in response to a complaint filed against a clinician.

Verbal Permission. We may also use or disclose your information to family members who are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Beth Harper, at 640 Holly Avenue, Winston Salem, NC 27101.

Right of Access. You can ask to see or get a copy of your PHI. You must make this request in writing. We will provide a copy or a summary of your PHI, usually within thirty days of your request. Your right of access may be restricted in certain situations, including situations in which having access may cause you harm. We may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication. Normally, we will communicate with you at the address and phone number you give us. You may ask us to communicate with you by other ways or at another location. Your request will need to describe how you want the information communicated and where. We are happy to honor your request as long as it is reasonable to do so. If you restrict us from providing information to your insurer, you also need to explain how you will pay for your treatment.

Fundraising. We may contact you for fundraising purposes, but you may tell us not to contact you again.

Breach Notification. If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Beth Harper, at 640 Holly Avenue, Winston Salem, NC 27101 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is June 2015.

Trinity Center, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Client Name:______________________________ Date of Birth:____________________

I have received Trinity Center Inc.'s Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Trinity Center, Inc.'s Notice of Privacy Practices is subject to change. I may obtain the most recent version by contacting Trinity Center, Inc. at 336.725.3999 or by visiting Trinity Center, Inc.'s website at www.trinitycenterinc.com.

My signature below acknowledges that I have received Trinity Center, Inc.'s Notice of Privacy Practices:

____ ____________________________

Signature of Client (or Parent/Guardian if client is a minor) Date

____

Client Name – Please Print

____

Parents/Guardian Name (if client is a minor) – Please Print

For Trinity Center, Inc. Use Only:
Inability to Obtain Acknowledgment of Receipt of Notice of Privacy Practices

If the client is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

____

____

Describe the steps taken to obtain the client's (or personal representative's) signature on the Acknowledgement:

____

____

Completed by:

_______________________________________ _________________________

Signature of Trinity Center, Inc. Representative Date

____

Print Name

Trinity Center, Inc.
Checking Your In-Network Insurance Benefits

Client Name: ____________________________________ Date Completed:______________________

Trinity Center requires that new clients check their insurance benefits before their first appointment in order to determine the appropriate charge for services. We are in network with most Blue Cross Blue Shield plans excluding Blue Value. Checking your benefits does not guarantee payment. It is only after your insurance company has made its first payment that you can be guaranteed the coverage amount. **You will need to bring this completed form and your current insurance card to your initial session.**

1. Contact your insurance company at the customer service number (usually found on the back of your insurance card). When you contact customer service let them know you are calling to determine your **mental health office visit** benefits. This term simply means that you are asking about mental health benefits and that Trinity Center is an office setting, rather than a facility or inpatient setting.

Your insurance company may require the following numbers for Trinity Center:	
Tax ID # 56-1337065	National Provider # 1700892478

2. Make sure you receive the following information:
   a. Is Trinity Center an in-network provider with my plan? _____________
   b. Do I have a deductible? ______________ How much? $____________________
   c. If yes, has any of the deductible been met? _______ How much? $____________
   d. When does this deductible renew (January 1 or another date)?

      ____
   e. Do I have a copay or co-insurance? What is the amount?

      Copay $___________ or Co-insurance _________%
   f. Is there a limited number of visits per year? _________ How many? __________
   g. Do these services require authorization? ________________________________

      If yes, what is my authorization number? _______________________________

It can be helpful to have service codes for the most common services provided at Trinity Center:

Counseling/Testing CPT Codes:
Initial Psychotherapy Intake 90791 (first visit, individual or couples)
Psychotherapy 60 min. 90837 (typical individual counseling session)
Family/Couples Therapy 90847 (couples counseling session)