SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

New Consumer Intake Demographic Form
(Please complete all fields **BLACK INK ONLY**)

Date of Intake:_____ Time of Intake:_____

Client Full Legal Name:_____

Maiden Name (if applicable):_____ Preferred Name: _____

Client Social Security #:_____ Date of Birth: _____

Physical Address: _____

City: _____ State: _____ Zip Code:_____

Main Contact #: _____ Alternate #: _____

Email address: _____

Mailing Address (if different than above):

Client Gender: ◯Male ◯Female ◯Other Pregnant: ◯Yes ◯No ◯N/A

Proficient in English: ◯Yes ◯No Secondary Language?: ◯Yes:_____

Marital Status: ◯Single ◯Married ◯Separated ◯Divorced ◯Widowed ◯Committed

Race: ◯Black ◯White ◯Hispanic ◯Native American ◯Asian ◯Multiracial
◯Other:_____

Does the client have a Legal Guardian and/or is the client a minor child? ◯Yes ◯No

Legal Guardian Name:_____

Relationship to client: _____ Phone #: _____

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

New Consumer Intake Demographic Form Cont'd
(Please complete all fields **BLACK INK ONLY**)

Highest Level of Education Completed: _____

Employment Status:
◯Employed full time ◯Employed part time ◯Student ◯Homemaker ◯Unemployed
◯Retired ◯Unable to work/Disabled ◯Active Duty Military ◯Veteran ◯Other Military

Living Arrangements:
◯Private Residence ◯Other independent housing ◯Homeless (shelter, car, etc.)
◯Group Home ◯Foster Home ◯Assisted Living ◯Other: _____

Accommodations for Handicapped needed: ◯Not Applicable
◯Physical Disability ◯Wheelchair/Mobility concerns ◯ Sign Language ◯Visually Impaired
◯ Intellectual Disability ◯Frail Senior ◯Language Interpreter ◯Deaf/Hearing Impaired

Have you ever been arrested? ◯Yes ◯No If yes, how many times in past year?:_____

Emergency Contact: _____

Relationship:_____ Phone Number:_____

Address:_____

Does the client have a Primary Care Physician?: ◯Yes ◯No
Name of Provider and/or Facility: _____

Contact #: _____ Address:_____

Anything else you would like us to know?

_____

_____

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

Financial Evaluation and Agreement Form

Primary Insurance Provider: _____

Insurance ID:_____ Subscriber Date of Birth:____/_____/_____

Subscriber Name if different than client: _____

Relationship to Subscriber: ◯Self ◯Dependent/Child ◯Spouse ◯ Legal Guardian ◯Other

Secondary Insurance Provide (if applicable):_____

Insurance ID:_____ Subscriber Date of Birth:____/_____/_____

Subscriber Name if different than client: _____

Relationship to Subscriber: ◯Self ◯Dependent/Child ◯Spouse ◯ Legal Guardian ◯Other

If you are unable to afford your appointments you may be eligible for sliding scale rates. Please provide the following information so we may consider you for this option.

Reported Monthly Income Amount for family: $_____

Number of individuals in the family: _____

To be completed by SDWC office staff

Staff verified Insurance: ◯Yes ◯No ◯Self Pay Staff Initials:_____

Eligible for Sliding Scale?: ◯Yes ◯No Signed Sliding Scale Agreement: ◯Yes ◯No

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

Consent to file Insurance Claims

I hereby authorize Sand Dollar Wellness Center PC to furnish information to insurance companies concerning my treatment. I hereby assign Sand Dollar Wellness Center PC all payments for services rendered to myself and/or my dependents. I understand that verification of benefits does not guarantee payment from my insurance provider. (Please be aware that your insurance claim may take up to 30 days to process. You will be invoiced once your claim has been processed with your insurance company, and payment is due upon receipt, unless a prior written payment plan has been agreed upon.)
I understand that I am responsible for any amount of service not covered by my insurance company. This will include, but not limited to, any deductibles, co-pays, co-insurance, and any denied services.

Payment is due to the time of service. We accept cash and all major credit cards. If you have insurance, the payment of your co-pay, co-insurance, and/or estimated patient portion is due at the time of service.

In signing this policy notice, I acknowledge that I have read and fully understand that I will be held responsible for any fees that my insurance company states not covered by policy or patient's responsibility.

Signature of Client/Legal Guardian:

_____

Date: _____/_____/_____

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

Policies and Procedures

Missed Appointments/Cancellations **Initials:**_____

If you need to cancel an appointment and/or reschedule it must be done with 24 hours or more in advance to avoid the $25.00 missed appointment fee. After 3 missed appointments Sand Dollar Wellness Center reserves the right to terminate continued services. You can cancel an appointment via phone 910-833-5902 or via email to our business manager, Tiffany, at trabil@sanddollarwellnesscenter.com. Emergency circumstances are, of course, taken into consideration.

Inclement Weather **Initials:**_____

Sand Dollar Wellness Center follows the New Hanover County Schools and Courts weather policy. If the schools and courts are closed, we will most likely be closed. However, please call to confirm. There will be no charges for appointments missed and rescheduled due to weather.

Insurance and Payments **Initials:**_____

If your insurance company rejects your eligibility or if there is a lapse in coverage, you fully responsible for the difference that is not paid (contracted rate/session) and the amount of the copay you have already paid. If you are using insurance, please use the Insurance Benefits Verification Form within this packet to verify your benefits before your initial session.

Fee Structure and Payments **Initials:**_____

90791: Intake/Assessment $125.00 **90837/34: Individual counseling** $95.00

Written or phone correspondence for more than 15 minutes: $25 per each additional 15 minutes.

Co-pays and deductible payments **are due at or before time of service by cash or credit.**

If for some reason payment is not made or processed during session, you will receive a statement/invoice to be paid within 30 days. After 60 days, Sand Dollar Wellness Center reserves the right to turn the balance over to Credit Collections along with a 25% administrative fee. This may adversely affect your credit rating so please be conscious of prompt payment.

Legal Matters and Fee Structure **Initials:**_____

Please understand that we must be fully informed regarding custody situations. If there is a custody agreement, provide your clinician with a copy of it along with any supporting documents. If your clinician is legally requested for court testimony, please know that your clinician is representing the child (in custody hearing) or the identified client. At times, your clinician's notes may be subpoenaed. Your clinician will write summary statements when notes are requested; all parties involved may request copies. Payments are expected the same as listed above and the same policies apply.

A non-refundable deposit of $500 if required 7 days prior to court date in order for your clinician to clear their schedule to attend, regardless if the court date is postponed. This deposit will go toward the per hour in-person court appearance amount.

- Phone consultation with attorneys: $150.00 per hour pro-rated
- Written reports and correspondence: $100.00 per hour pro-rated
- "Stand-by" consultation on day of court: $100.00 per hour pro-rated
- In-person court appearance: $250.00 per hour including travel time
- Expert Letter of Recommendation to Judge $75.00 per hour (minimum 2 hours)

I have read and understand the policy and procedures of Sand Dollar Wellness Center. My signature below acknowledges my agreement to adhere to the expectations and I understand my obligations.

_____ _____
Signature of Client/Legal Guardian Date

_____ _____
Printed Name of Client/Legal Guardian Witness (if necessary)

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

Consent for Treatment

I hereby give my consent to Sand Dollar Wellness Center to provide evaluation, psychological testing, treatment and/or any other services that we may mutually determine appropriate. I understand that services will be rendered in a professional manner, consistent with my clinician's accepted ethical standards of practice.

I understand that I will likely gain the most benefit from therapy and other treatment services if I am committed to the process and attend regularly. I also understand that it is not uncommon, over the course of therapy, to temporarily experience increased distress. This is an indicator that important work is underway and significant changes are beginning. I understand that no promises have been made to me as to the results of treatment or any procedures provided by my therapist at Sand Dollar Wellness Center.

I acknowledge that I have received and read the privacy policy packet of Sand Dollar Wellness Center. I understand that I may ask questions at any time about any of the information given to me, and about treatment options. In addition, I am aware of the constraints involved with confidentiality.

I understand that the fee for the initial assessment is $125.00 and $95.00 for subsequent therapy sessions. I have read the fee schedule and understand that I must cancel an appointment with at minimum 24 hours in advance or I will be assessed a $25.00 missed appointment fee. Payment is due and payable to Sand Dollar Wellness Center at the beginning of each session and can be paid by **cash or credit card.** I understand if payments are not made the therapist has the right to discontinue treatment. I understand that phone calls will be returned to me within a 24-hour period. If I am in an emergency situation I will either follow the crisis plan developed with my clinician, call Mobile Crisis **1-844-709-4097 or will go directly to my local emergency room.**

Client/Legal Guardian Signature: _____

Client/Legal Guardian Printed Name: _____

Date: _____

***Consent for Treatment of Children and Adolescents:**

I give Sand Dollar Wellness Center consent to treatment my minor child: _____
Minor Child Name

Signature of Parent or Legal Guardian:_____ Date: _____

Relation to Client: _____

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

Consent of Non-Secure Forms of Electronic Communication

Sand Dollar Wellness Center strives to be available to our clients in multiple different ways. Feel free to contact us in the following ways regarding scheduling, changing of appointments, tardiness, or non-clinical emergencies:

- Office Phone: 910-833-5902
- Office Manager Email: trabil@sanddollarwellnesscenter.com

However, please be advised that confidentiality cannot be guaranteed using these media sources. Electronic Communication such as Gmail and Skype are not considered "secure." While we do not share any accounts/passwords and take strong efforts to protect your confidentiality, there is some risk that any PHI (protected health information) contained in email/phone/voicemail/skype/text may be disclosed to or intercepted by unauthorized third parties.

All-important communications, including any personal clinical information, are to be done in person

Notice Regarding Social Media and Online Presence

We maintain a professional and personal online presence via various social media/networking platforms. Our therapist's policy is to deny any personal connection requests by clients, although you are welcome to follow our professional pages or blogs. However, please know that any social media private messages will be deleted or ignored, as communication should be made in-person, or via email or phone. While we will never address you online, it does not protect you from others inferring you are in treatment.

By signing below, you are acknowledging that you realize email and phone communication does not provide a completely secure means of communication.

Your treatment will not depend on you giving consent. You also have the right to terminate this agreement at any time.

I give my permission for Sand Dollar Wellness Center to contact me using non-secure methods regarding reminders, scheduling, or other relevant matters, and I understand all risks involved:

Email/Text Communication: ◯Yes ◯ No

Phone/Voicemail Communication: ◯Yes ◯ No

Client/Legal Guardian Signature: _____ Date: _____

Client/Legal Guardian Printed Name: _____ Date: _____

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

ACKNOWLEDGEMENT OF RECEIPT PRIVACY NOTICE

I hereby acknowledge receipt of the Sand Dollar Wellness Center "PRIVACY NOTICE" packet.

I received a copy of this material on the date indicated below.

Date: _____

_____
Client/Legal Guardian Signature

_____
Witness Signature

_____
Print Client/Legal Guardian Name

_____
Print Witness Name

Discharge Policy Notification Attestation

I have read and been given the opportunity to ask questions regarding Sand Dollar Wellness Center's Discharge Policy. I have been offered a physical copy of this document upon request and been made aware it is located on SDWC's website at www.sanddollarwellnesscenter.com (Also, a physical copy located on the lobby corkboard for future reference).

I understand that consistent engagement with recommended services is a vital part of my recovery. I understand that I must call at least 24 hours in advance to reschedule appointments. I understand that if I fail to show up for **2 or more** scheduled appointments without notice that I will be at risk of being discharged from all services at SDWC.

_____
Client/Legal Guardian Signature and Date

_____
Client/Legal Guardian Printed Name

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
45 C.F.R. Parts 160 and 164; 42 C.F.R Part 2; G.S. 122C

This authorization form implements requirements for individual authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R, Part 2), and the state confidentiality law governing mental health, developmental disabilities and substance use services (G.S. 122C).

I, _____ (DOB:) _____authorize Sand Dollar Wellness Center &

_____to communicate with and disclose to one another.

THIS INFORMATION/DATA WILL INCLUDE:

- ⊗ ASSESSMENTS
- ⊗ PSYCHOLOGICAL EVALUATIONS
- ⊗ DEVELOPMENTAL INFORMATION
- ⊗ SUBSTANCE USE INFORMATION
- ⊗ PSYCHIATRIC EVALUATIONS
- ⊗ MEDICAL INFORMATION
- ◯ HIV/AIDS INFORMATION
- ⊗ SOCIAL HISTORY AND INFORMATION
- ⊗ SERVICE PLANS/GOALS
- ⊗ SERVICE NOTES
- ⊗ DISCHARGE SUMMARY

◯ OTHER: _____

PURPOSE OF USE OR DISCLOSURE:

- ⊗ AT THE REQUEST OF THE INDIVIDUAL
- ⊗ ASSESSMENT/EVALUATION
- ⊗ COORDINATION OF SERVICES
- ◯ COURT PROCEEDINGS
- ◯ DETERMINATION OF BENEFITS
- ◯ OTHER: _____

INFORMATION REQUESTED SHOULD BE FAXED TO THIS Number: 910-833-5905

REDISCLOSURE:

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R Part 2), protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance use treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws. Our Privacy Policy describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke authorization, as well as the exceptions of my right to revoke, are explained in the Sand Dollar Wellness Center Privacy Practices, a copy of which has been given to me.

If not revoked, this consent shall be valid for 1 YEAR from the date signed unless otherwise indicated here:

_____

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this form. I understand that Sand Dollar Wellness Center will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____

Client/Legal Guardian Signature | Staff Signature

_____ _____

Date | Date

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
45 C.F.R. Parts 160 and 164; 42 C.F.R Part 2; G.S. 122C

This authorization form implements requirements for individual authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R, Part 2), and the state confidentiality law governing mental health, developmental disabilities and substance use services (G.S. 122C).

I, _____ (DOB:) _____authorize Sand Dollar Wellness Center &

Emergency Contact-_____to communicate with and disclose to one another.

THIS INFORMATION/DATA WILL INCLUDE:

◯ ASSESSMENTS ◯ PSYCHOLOGICAL EVALUATIONS ◯ DEVELOPMENTAL INFORMATION
◯ SUBSTANCE USE INFORMATION ◯ PSYCHIATRIC EVALUATIONS ◯ MEDICAL INFORMATION
◯ HIV/AIDS INFORMATION ◯ SOCIAL HISTORY AND INFORMATION ◯ SERVICE PLANS/GOALS
◯ SERVICE NOTES ◯ DISCHARGE SUMMARY

⊗ OTHER: _____emergency info only_____

PURPOSE OF USE OR DISCLOSURE:

◯ AT THE REQUEST OF THE INDIVIDUAL ◯ ASSESSMENT/EVALUATION ◯COORDINATION OF SERVICES
◯ COURT PROCEEDINGS ◯ DETERMINATION OF BENEFITS

⊗ OTHER: _____emergency info only_____

INFORMATION REQUESTED SHOULD BE MAILED TO THIS ADDRESS:

_____

REDISCLOSURE:

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R Part 2), protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance use treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws. Our Privacy Policy describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:

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If not revoked, this consent shall be valid for 1 YEAR from the date signed unless otherwise indicated here:

_____

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this form. I understand that Sand Dollar Wellness Center will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____
Client/Legal Guardian Signature Staff Signature

_____ _____
Date Date

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
45 C.F.R. Parts 160 and 164; 42 C.F.R Part 2; G.S. 122C

This authorization form implements requirements for individual authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R, Part 2), and the state confidentiality law governing mental health, developmental disabilities and substance use services (G.S. 122C).

I, _____ (DOB:) _____authorize Sand Dollar Wellness Center &

Primary Care Provider- _____ to communicate with and disclose to one another.

THIS INFORMATION/DATA WILL INCLUDE:

⊗ ASSESSMENTS	⊗ PSYCHOLOGICAL EVALUATIONS	⊗ DEVELOPMENTAL INFORMATION
⊗ SUBSTANCE USE INFORMATION	⊗ PSYCHIATRIC EVALUATIONS	⊗ MEDICAL INFORMATION
◯ HIV/AIDS INFORMATION	⊗ SOCIAL HISTORY AND INFORMATION	⊗ SERVICE PLANS/GOALS
	⊗ SERVICE NOTES	⊗ DISCHARGE SUMMARY

◯ OTHER: _____

PURPOSE OF USE OR DISCLOSURE:

⊗ AT THE REQUEST OF THE INDIVIDUAL ⊗ ASSESSMENT/EVALUATION ⊗ COORDINATION OF SERVICES

◯ COURT PROCEEDINGS ◯ DETERMINATION OF BENEFITS

◯ OTHER: _____

INFORMATION REQUESTED SHOULD BE FAXED TO THIS Number: 910-833-5905

REDISCLOSURE:

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R Part 2), protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance use treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws. Our Privacy Policy describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke authorization, as well as the exceptions of my right to revoke, are explained in the Sand Dollar Wellness Center Privacy Practices, a copy of which has been given to me.

If not revoked, this consent shall be valid for 1 YEAR from the date signed unless otherwise indicated here:

_____

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this form. I understand that Sand Dollar Wellness Center will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____
Client/Legal Guardian Signature

_____
Staff Signature

_____
Date

_____
Date

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

Client Bill of Rights

- Each client has the right to impartial access to treatment, regardless of race, religion, sex, sexual preferences, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided
- Each client has the right to accept or refuse all or part of his/her care and/or have the expected consequences explained
- Each client has the right to expect that all treatment records or information will be kept confidential in compliance with agency policy except as authorized and as required by law. No information/records will be released without written permission of client or other appropriate designee, except to the physician, insurance company or hospital/facility client transferred to. The client will have access to all their health care records.
- Each client has the right to exercise personal privacy by withholding consent or family's or significant other's participation and to be informed of the possible consequences of that action
- Each client has the right to be informed of the nature and purpose of any services rendered and the title of personnel providing that service
- Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on their service provided and be aware of the process of voicing those grievances.
- It is the right of each client to receive individualized treatment which includes:
    - Adequate and humane services regardless of the source of financial support
    - Services provided in the least restrictive environment possible
    - An individualized treatment plan, which is reviewed periodically and as needed
    - To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate
- If at any time during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency – they have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.
- The client has the right to request a referral for services, which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.
- The client will be informed of his/her rights in a language they understand
- Each client has the right to refuse to participate in any research projects without compromising their access to the organizations resources
- Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.
- Each client has the right to make decisions regarding the withholding or resuscitative measures with these decisions respected per agency policy.

I have read and understand the above Bill of Rights and I am aware that a copy is available to me upon my request.

Client/Legal Signature: _____ Date: _____

SAND DOLLAR WELLNESS CENTER

Client Name:
DOB: MRN:
Insurance:

Treatment History

History of Past INPATIENT Psychiatric or Substance Use Treatment ☐ None ☐ Client Cannot Remember

Location	Dates	Reason for Hospitalization/Outcome	Release Obtained?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Current and Past OUTPATIENT Mental Health and/or Substance Use Treatment ☐None ☐ Client Cannot Remember

Location	Dates	Reason for Treatment/Outcome	Release Obtained?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

CURRENT Medications (*include over the counter, herbals, vitamins, etc.)* ☐None ☐ Client Cannot Remember

Medication	Dosage/Duration	Route of Administration	Who Prescribes	Efficacy/Side Effects	Release Obtained?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Anything else you would like us to know?

_____

_____

_____