LUCY DANIELS CENTER FAMILY GUIDANCE SERVICE
REGISTRATION INFORMATION

Family Information

Child:

Full name / Nickname _____ Gender _____

Date of birth / Place of birth _____

Resides with: _____

Parent / Guardian # 1:

Full name _____

Address/City/State/Zip _____

Telephone Numbers Home _____ Cell _____ Business _____

E-mail address _____

Social Security # _____

Date of birth / Place of birth _____

Occupation / Place of business _____

Parent / Guardian # 2:

Full name _____

Address/City/State/Zip _____

Telephone Numbers Home _____ Cell _____ Business _____

E-mail address _____

Social Security # _____

Date of birth / Place of birth _____

Occupation / Place of business _____

Sibling One:

Full name / Nickname _____ DOB _____ Gender _____

Sibling Two:

Full name / Nickname _____ DOB _____ Gender _____

Sibling Three:

Full name / Nickname _____ DOB _____ Gender _____

Sibling Four:

Full name / Nickname _____ DOB _____ Gender _____

Lucy Daniels Center Consent for Evaluation and Treatment

CHILD'S NAME: _____ DOB: _____

I voluntarily consent that I will participate in a mental health evaluation and/or treatment at the Lucy Daniels Center. I understand that complete and accurate information will be provided concerning the Center's professional judgments about each of the following areas for my child:

- The benefits of the proposed treatment
- Alternative treatment modes and services
- The manner in which treatment will be provided
- Possible adverse effects from the treatment if any
- Implications of declining treatment

The evaluation or treatment will be conducted by a licensed mental health clinician in the state of North Carolina. Provisionally licensed clinicians will be supervised by a staff licensed clinician. Evaluation and treatment can include diagnostic interviews with parents, children; psychological testing; psychiatric evaluation and medication management; parent counseling; home visits; consultation with schools or with other professionals involved in the child's care; psychotherapy with child or with family units; and daytreatment.

Benefits and Risks to Evaluation/Treatment: Possible benefits to treatment include decrease in child's symptoms, enhancement of social and academic functioning, improvement in family relationships and quality of life, and increased awareness of strengths and limitations. In general, there is little risk in evaluation/treatment, however, because it often involves discussing or confronting painful feelings and experiences, children or parents may feel emotionally uncomfortable at times. Additionally, there are potential side effects of the use of medications.

Emergency Services: Lucy Daniels Center provides clinical services during usual business hours, Monday through Friday, with the exception of holidays during which the Center is closed. With the exception of provisions for Medicaid clients, the Center does not provide after hours or weekend services.

> **For all families other than those covered by Medicaid:** In the event of an urgent situation during usual working hours (Monday – Friday, 8:30AM – 5:00 PM, other than LDC holiday days), please call the Center at 919 677-1400 and leave a voice mail for your clinician. Alternatively, if the situation requires immediate response, please so indicate to the receptionist or other Lucy Daniels Center personnel who will inform your clinician immediately. If your clinician is unable to respond for some reason in a suitable timeframe, or if the emergency occurs outside of working hours, please call 911 or consult one of the resources listed below.
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> **For all families covered by Medicaid:** Lucy Daniels Center provides a 24 hour/7 day a week service for emergencies for families covered by Medicaid. The service is solely for the purpose of assisting with emergency situations that involve threats to life or health, and is not for the purpose of providing counseling for otherwise difficult situations. If a life or health threatening situation arises during

Lucy Daniels Center Consent for Evaluation and Treatment (continued)

business hours (Monday – Friday, 8:30AM – 5:00 PM, other than LDC holiday days), please call the Center at 919 677-1400 and leave a voice mail for your clinician. Alternatively, if the situation requires immediate response, please so indicate to the receptionist or other Lucy Daniels Center personnel who will inform your clinician immediately. If your clinician is unable to respond for some reason in a suitable timeframe, or if the emergency occurs outside of working hours, please call 911 or consult one of the resources listed below. If a life or health threatening situation occurs after business hours, please call 919 624-4190. This line will rotate among staff. In the event that you cannot reach a clinician in a timely enough way after hours, we recommend that you consult one of the resources listed below.

- Holly Hill Hospital 24 hour hotline: 919 250-7000
- Therapeutic Alternatives Mobile Crisis Team 877 626-1772
- Wake Crisis and Assessment Services: 919 250-12160
- Local Emergency Room

Handling Concerns: Lucy Daniels Center is committed to offering excellent services for each child and parent. It is important that parents bring up any concerns that arise with the person most directly involved in a timely manner. If the problem cannot be satisfactorily resolved, the next step would be to discuss the situation with the Clinical Director; if the Clinical Director is part of the concern to be addressed, the Education Director will appoint a substitute.

Confidentiality: Within the parameters of my child's right to confidentiality, parents may obtain information regarding the progress and outcome of the above-named services by contacting child's therapist.

I understand that I may revoke, in writing, this consent at any time except to the extent that action based on this consent already has been taken. This consent will expire 365 days after the date below. This authorization and request is fully understood and made voluntarily on my part. By signing below, I affirm I am legally authorized to give consent on behalf of my child. In cases of shared legal custody or in the absence of documentation regarding custody, consent to evaluate and provide treatment must be provided by both parents.

_____ _____

Signature Relationship to Child Date

_____ _____

Lucy Daniels Center Representative Date

Lucy Daniels Center Consent to Release Personal and Medical information

Client's Name:_____ DOB: _____

Pediatrician/Family Physician name and Group: _____

Phone#_____ Address: _____

Is this the referring Pediatrician or Physician? Yes ☐ No ☐

Medical Physician: It is customary for the Lucy Daniels Center to send a letter to your child's pediatrician(s) or family physician(s) to notify them that you have accessed services at our Center on your child's behalf, or to send them a report of your child's evaluation. We do this because your child's overall health care will benefit when your child's medical physician is knowledgeable about your child's emotional health. It is entirely within your rights to decline this service.

LDC has permission to: **release** ☐ **Obtain** ☐ **Release and Obtain** ☐ **No Permission** ☐
information with my child's medical physician/healthcare provider. (*Check one)*

School or other source: It is often helpful for the Lucy Daniels Center to obtain information from your child's teacher(s), other school personnel or agency that has direct involvement with your child. It is entirely within your rights to decline this service.

LDC has permission to **release** ☐ **Obtain** ☐ **Release and Obtain** ☐ **No Permission** ☐
information with my child's school or other source. (*Check one*)

If permission is provided to release and/or obtain information:
School or other source name: _____Phone #_____

Address: _____

Description of Information to be Disclosed If permission is provided to release and/or obtain information to medical physician or school or other source, please initial each item that LDC is permitted to disclose:

_____ Assessment and Diagnosis _____ Psychological Testing _____ Treatment Plan and Final summary

_____ Substance abuse and HIV/aids information

I understand that the information named in this consent will be used for the purposes of the evaluation and treatment of my child. My right to confidentiality has been explained to me and I understand what information will be released or obtained, the need for the information, and that State statutes and regulations protect the confidentiality of authorized information. I understand that I may revoke, in writing, this consent at any time except to the extent that action based on this consent already has been taken. This consent will expire 365 days after the date below. The authorization and request is fully understood and made voluntarily on my part. By signing below, I affirm that I am legally authorized to give consent on behalf of my child.

_____ _____ _____
Signature of legal guardian: Relationship to child Date:

Lucy Daniels Center
Family Insurance Information

Client Name: _____ Date of Birth_____

POLICY HOLDER'S INFORMATION

Primary Insurance Company: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Gender: ☐ Male ☐ Female

Social Security #: _____ Policy ID# (if different from SSN):_____

Group number: _____ Group Name: _____

Client's Relationship to Policy Holder: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Client Has No Active Insurance ☐

Lucy Daniels Center participates with many but not every insurance plan, and files the claims to the insurance plans in which we participate. **LDC does not file claims for any insurances in which we do not participate.**

Each insurance plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. Although LDC will help sort this out to the extent possible, it is ultimately your responsibility to check with your insurance company to determine covered benefits, as the agreement of the insurance carrier to pay for health care is a contract between you and the insurance company.

I authorize the Lucy Daniels Center to disclose to my third party insurer (including but not limited to commercial insurance companies, Medicaid, Health Choice) clinical and/or medical information necessary to determine eligibility and process payment. I request that payment for benefits be made on my behalf to the Lucy Daniels Center for any eligible services provided.

_____ _____

Signature Relationship to Child Date

Lucy Daniels Center Family Guidance Service Fee Agreement

CHILD'S NAME: _____ DOB: _____

Families are responsible for paying their full current financial obligation on each date of service. Please understand that we maintain this expectation under all circumstances without exception.

I: INSURANCE PROVIDERS

Lucy Daniels Center contracts with most insurance providers. If you are covered by an insurance provider with whom LDC contracts, you will be responsible for any deductible and co-payments required by your insurance provider. LDC will bill and collect payments from your insurance provider, and send you a monthly statement that summarizes all payments. You are responsible for full payment for uncovered services, including sessions beyond limits covered by insurance providers.

We accept Medicaid for recipients who do not have other third-party coverage. We do not accept Medicaid for recipients who have other third-party coverage.

Occasionally we do not contract with a family's insurance provider. In that event, you would be responsible for the full payment of all fees at the time of service (see fee schedule.)

Families without health insurance or who choose not to use the insurance are responsible for all fees.

Families covered by Medicaid or North Carolina HealthChoice will not have any out-of-pocket financial obligation of any sort for any services, covered or uncovered.

II: NON-COVERED SERVICES (BY INSURANCE PROVIDERS)

Many services necessary to provide care for your child are "non-covered" by insurance providers.

- Diagnostic Fee ($150): On many occasions, we recommend that we conduct a diagnostic assessment on a child so that we can achieve a better understanding of the child's challenges and how to help. **All evaluations (except those for families covered by Medicaid or NC Health Choice) will have a diagnostic fee of $150 that helps to cover our cost for many non-covered activities beyond the clinician's visits with parents and child.** These non-covered services include: establishing the records and billing, communicating (administrator and/or clinician) with insurance provider, clinician reviewing records including developmental history, clinician contacting school or other professionals by phone or letter, clinician record keeping, and clinician phone conversations with parents.

The following non-covered fees may or may not be a part of any particular evaluation:

- School observation ($150): Provided by a Lucy Daniels Center child development specialist, including approximately one hour observation, travel time, report generation, and consultation with clinician.
- School consultations ($150/hr.): Any conference or consultation with school personnel, in person or by telephone, including travel time.

Although you can expect that the diagnostic fee, school observation, and school consultation will not be covered services by your insurance company, there are rare exceptions, and we will inform you in those instances.

III: PSYCHOLOGICAL TESTS

We may recommend that we administer and interpret psychological tests as part of our overall assessment. These tests are provided by our psychological staff and are generally covered, at least to some degree, by health insurance. There is a great deal of variability with regard to out-of pocket expense for psychological testing, depending upon an individual's insurance coverage and the particular testing required. We will provide information about the expense of the recommended testing before we begin the testing so that you would know the estimated expense.

Lucy Daniels Center Family Guidance Service Fee Agreement (continued)

IV: UNDISCOUNTED FEE SCHEDULE

The Lucy Daniels Center's undiscounted fee schedule applies to families who are in the deductible period, who are not using insurance with an insurance provider with whom Lucy Daniels Center contracts, or who are paying "out of pocket" for other reasons. Although we accept contracted (discounted) amounts with providers with whom we have contracted as full payment due (in addition to the co-payments) for covered services, our statements to the insurance providers will generally show our full, undiscounted fee.

- For most types of sessions, our undiscounted fee is:
- Clinical Social Worker (L.C.S.W.): $125.00/45-50 minute session
- Psychologist (Ph.D. or Psy.D.): $150 - $200/45-50 minute session
- Psychiatrist (M.D.): $150 – $250/ 45-50 minute session

V: ADDITIONAL POLICIES

- Account must be paid in full at each visit with personal check, health savings account check, or cash. We **DO NOT** accept credit or debit cards. An administrative fee of $35 applies on each occasion that account is not paid in full.
- Statements will be mailed or emailed monthly. Balances that are shown on the statements may change subject to the resolution of insurance claims.
- We charge a $25.00 fee for checks returned for non-payment for any reason.
- We have a sliding scale fee (need based fee reduction) for qualifying families who do not have insurance coverage.
- We ask that you make every effort to keep appointments. We charge a $50.00 fee for appointments that are cancelled. These sessions cannot be submitted for insurance reimbursement.

  There are only two conditions under which we will waive the cancellation fee:

  - Grace period: We will waive the fee if the appointment is cancelled no later than 48 before the time of the appointment.
  - Illness: On an honor system, parents will not be charged for appointments that are canceled because of illness on the part of parent or child, up to the time that the appointment is scheduled to begin. Please cancel a session when your child has any symptoms that we describe in our guidelines. The session must be canceled in advance of the session time in order for the cancellation fee to be waived.
  - **There are absolutely no exceptions to the cancellation policy.** We understand that conflicts may come up that will make it difficult or impossible for you to keep an appointment. Nevertheless, we will charge under any and all circumstances, other than the exceptions described above. **Our staff does not have the discretion to make exceptions to this policy.** Our $50.00 fee for cancellations is a compromise amount that takes into account the possibility that the cancellation was unavoidable and that we cannot use that cancelled hour for revenue generation. The fee for a missed session is due at the time of the next appointment in accordance with our policy that your account is paid in full at the time of each session.

I have read and agree to the provisions of the Lucy Daniels Center fee policies as described above

_____		_____
Signature	Relationship to Child	Date
_____		_____
Signature	Relationship to Child	Date

Lucy Daniels Center
Helping children live emotionally healthy lives

Dear Parent(s):

We collect general demographic and referral information from the families we serve for the purposes of being able to design appropriate services as well as to obtain external funding. Your information will be used in an aggregate way and will not be identifiable in any way, including to Lucy Daniels Center staff. Thank you for taking a few extra minutes to provide this information.

1. **Birth Year of Child:** _____

2. **Number of household members:** □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 or more

3. **Gender of child:** □ Female □ Male

4. **Heritage (check all that apply):**

   □ White □ African American □ Hispanic □ East Asian □ South Asian
   □ Native American □ African □ Multicultural □ Other

5. **City and County:** _____

6. **Zip Code:** _____

7. **Total household income (Gross unadjusted salaries before deductions):**

   □ under $30,000 □ $30,000 – $49,999 □ $50,000 – $75,000
   □ $75,000 – $100,000 □ over $100,000

8. **Qualify for free/reduced lunch:** □ yes □ no/don't know

9. **Please indicate how you decided to consult the Lucy Daniels Center (check more than one if appropriate):**

   □ recommendation from pediatrician
   □ recommendation from mental health professional
   □ recommendation from childcare professional
   □ recommendation from teacher in kindergarten, elementary or middle school
   □ recommendation from another organization (specify)

   _____

   □ recommendation from prior client of Lucy Daniels Center
   □ recommendation from friend
   □ recommendation from insurance company or insurance panel list
   □ website
   □ Carolina Parent articles
   □ media Source other than Carolina Parent
   □ Lucy's Book Club
   □ other (specify) _____

Lucy Daniels Center 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 or your child's health record contains personal information about you, your child and his or her health. This information that may identify you and that relates to you or your child's past, present or future physical or mental health or condition or 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. It also describes your rights regarding how you may gain access to and control your PHI.

We maintain the privacy of PHI and are providing 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 provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

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 healthcare treatment and related services. This includes consultations with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

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 your insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it become necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for collection.

For Healthcare 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 training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, 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: Applicable law and ethical standards permit us to disclose information about you or your child without your authorization only in a limited number of situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as licensing boards or the health department)
- Required by a Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health and 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.

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

Lucy Daniels Center Notice of Privacy Practices (continued)

With authorization: Uses and discloses 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 your PHI. To exercise any of these rights, please submit your request to our Privacy Officer at Lucy Daniels Center.

- Right of Access to Inspect and copy: You have the right, which may be restricted only in exceptional circumstances to inspect and copy PHI that may be use to make decisions about you or your child's care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or your child. We may charge a reasonable cost based fee for copies.
- Right to Amend: I 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.
- Right to an Accounting of Disclosures: You have the right to request an accounting of certain of the disclosure 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 or your child's PHI for treatment, payment or health care operations. We are not required to agree to your request.
- Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, subject to our judgment about the reasonableness of the request.
- 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 at LDC Family Guidance Service or with the Secretary of Health and Human Services or by calling 202-619-0257. LDC will not retaliate for the filing of a complaint.

I acknowledge that I have read and agree to the Notice of Privacy Practices of the Lucy Daniels Center.

Child's Name: _____ DOB: _____

Parent Name: _____ Relationship: _____

_____ _____

Signature of Acknowledger Date:

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)