NEW CLIENT INFORMATION PACKET

Carol Pulley

Licensed Psychological Associate

NC #3453

828-964-8790

My name is Carol Pulley and I am a Licensed Psychological Associate. I have been licensed to practice in North Carolina since 2007. I earned a Master's Degree in Clinical Psychology from Appalachian State University. I am devoted to providing my clients with clinically appropriate treatment in the most respectful manner possible. All services provided respect your rights to confidentiality and privacy. Our work together will be a collaborative or team effort in which we both work to achieve clearly formulated treatment/assessment goals. Please feel free to ask any questions you may have regarding treatments, payments, or me.

I work under the supervision of Dr. Denise Martz, PhD. and may share information with her as clinically appropriate.

If you have any questions or would like additional information, please feel free to ask.

Mandatory Disclosure Statement

Client Rights and Important Information

You are entitled to receive information from me about my methods of therapy/assessment, the techniques I use, the duration of your assessment and my fee structure. I will provide you with this information in our first meeting.

As a client, you have the right to choose a counselor/therapist who best suits your needs and purposes. Please be advised that you may ask questions about treatment at any time, and you may also choose to terminate/end therapy at any time.

In Case of Emergency

If you have an urgent situation that you feel needs immediate support and I am not available in my office or by phone, please contact one of the following:
(1) Your primary care physician
(2) Go to the nearest hospital emergency room;
(3) Call the Daymark Services Crisis Line. 877-492-2785.

For LME/MCO or Medicaid Clients: You may call the Smoky Mountain 24-hour Access / Crisis Number: 800-849-6127 or the Partners 24-hour Access / Crisis Number: 1-888-235-4673.

Termination of Treatment

If you decide to terminate therapy, you understand that it can be helpful to discuss termination with your therapist. Carol Pulley reserves the right to discontinue therapy due to continual cancellations, lack of payment, etc.

Initial _____

Complaint Procedures

If you are dissatisfied with any aspect of the counseling/assessment process, please inform me so we can determine if our work together can be more efficient and effective or if referral is appropriate.
If you think I have treated you unfairly or unethically, and we cannot resolve the problem, contact: The North Carolina Psychology Board or Disability Rights of North Carolina Complaint Hotline: 1-800-624-3004 (within N.C.) or 919-855-4500.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential with some exceptions.

Initial _____

PRIVILEGED COMMUNICATION

Sections from Chapter 8 of the North Carolina General Statutes:

Sec. 8-53.3. Communications between psychologist and client or patient.

No person duly authorized as a licensed psychologist or licensed psychological associate, nor any of his or her employees or associates, shall be required to disclose any information which he or she may have acquired in the practice of psychology and which information was necessary to enable him or her to practice psychology. Any resident or presiding judge in the district in which the action is pending may, subject to G.S. 8-53.6, compel disclosure, either at the trial or prior thereto, if in his or her opinion disclosure is necessary to a proper administration of justice. If the case is in district court the judge shall be a district court judge, and if the case is in superior court the judge shall be a superior court judge.

Notwithstanding the provisions of this section, the psychologist-client or patient privilege shall not be grounds for failure to report suspected child abuse or neglect to the appropriate county department of social services, or for failure to report a disabled adult suspected to be in need of protective services to the appropriate county department of social services. Notwithstanding the provisions of this section, the psychologist-client or patient privilege shall not be grounds for excluding evidence regarding the abuse or neglect of a child, or an illness of or injuries to a child, or the cause thereof, or for excluding evidence regarding the abuse, neglect, or exploitation of a disabled adult, or an illness of or injuries to a disabled adult, or the cause thereof, in any judicial proceeding related to a report pursuant to the child Abuse Reporting Law, Article 3 of Chapter 7B, or to the Protection of the Abused, Neglected, or Exploited Disabled Adult Act, Article 6 of Chapter 108A of the General Statutes.

Initial _____

RELEASE OF INFORMATION

You will receive a copy of your (or your child's) treatment plan/assessment and may request a copy at any time. If you would like to me to release your records to another provider/agency/school, you may request a Release of Records form. All requests disclosure of health information must be in writing and signed by the parent/legal guardian/personal representative. Legible facsimiles are acceptable. A release form will be provided upon request. The signed form can be mailed or faxed.

Mail to: P.O. Box 56
Roaring Gap, NC. 28668
Fax to: 888.544.6736

Initial _____

Clients Rights General Statutes 122C-51 Declaration of policy on clients' rights.

It is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment. It is further the policy of this State that each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities.

Assessment and Treatment or Service Plan. The plan shall include: written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

Disability Rights North Carolina is a private nonprofit organization. Designated by the Governor in 2007 to ensure the rights of all state citizens with disabilities through individual advocacy and system change, DRNC is part of a national system of federally mandated independent disability agencies. DRNC is completely independent of government and the disability service system in order to be free of any conflicts of interests which would undermine our capacity to advocate vigorously on behalf of the human and legal rights of people with disabilities. If you feel your rights are being violated or that you require assistance, you may contact Disability Rights North Carolina.

Address : 2626 Glenwood Avenue Suite 550, Raleigh, NC. 27608
Telephone: Voice (919) 856-2195 Toll Free Voice (877) 235-4210, TTY 888-268-5535
Fax: (877) 235-4210
Email: info@disabilityrightsnc.org

Initial _____

Payment Agreement

It is understood that the client, not the client's insurance company or the client's employer, is responsible for the full payment of services rendered. The client is responsible for co-pay/coinsurance, unmet deductibles, and any unpaid insurance balance at the time of each visit. If you would like an insurance billing form sent to your insurance company, then please sign below.

If a scheduled appointment is missed, a charge of $50.00 will be made unless the appointment is cancelled 48 hours in advance. If two or more appointments are missed without 48 hours' notice the client may be dismissed from the practice for a period of 3-6 months.

FINANCIAL RESPONSIBI LITY: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services rendered to the patient, he/she hereby individually is obligated to pay Carol Pulley M.A. the full charges as incurred over the course of treatment, including those fees not paid by the insurance carrier and/or other sources of financial support or benefit. In the event that it might become necessary to refer the account to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. Please discuss these matters with Carol Pulley if you have any further questions.

I authorize the release to the insurance company of the required medical information necessary to process this claim. I authorize the payment of medical/psychotherapy benefits to the named provider for services rendered.

Your signature below indicates that you have read and received a copy of this document and had the opportunity to ask any questions.

_____ _____

Printed Name Relationship to Client

_____ _____

Signature Date

Carol Pulley M.A- Licensed Psychological Associate- P.O. BOX 56 Roaring Gap, NC 28668

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ Date of Birth_____

Client Medical Record #_____Client SS # *(Optional)*_____

I_____hereby authorize
(Client or Personal Representative)
_____to disclose specific health information
(Name of Provider/Plan)
from the records of the above named client to: _____
(Recipient Name/Address/Phone/Fax)

_____

_____

for the specific purpose(s): _____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

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NOTE: This Authorization was revoked on _____ _____

(Date) *(Signature of Staff)*

Carol Pulley M.A- Licensed Psychological Associate- P.O. BOX 56 Roaring Gap, NC 28668

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____

(*Enter Name of Person Who Signed Authorization)* *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any action
(Date)

taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*