Pamlico River Behavioral Health
100 E Main Street
Washington NC 27889
Phone: 252-940-1611 Fax: 252-9401752 E-mail: prbh@prbhealth.net

Patient Registration

Client Full Name: _____ Date of Birth: _____

Age: _____ Address: _____ City: _____ Zip Code: _____

Phone Number: _____ E-Mail: _____

Currently Seeing Another Mental Health Provider? ☐ Yes: _____ ☐ No

Emergency Contact Name: _____ Phone Number: _____

In case of an emergency, I consent Pamlico River Behavioral Health to obtain emergency medical care for me and contact the emergency contact listed above.

I consent to being contacted through email and/or text messaging by Pamlico River Behavioral Health therapists or staff at the contact information provided.

Signature: _____ Date: _____

Insurance Information

Insurance Company (if applicable): _____

I authorize Pamlico River Behavioral Health to file their services with my insurance company.

Signature: _____ Date: _____

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Consent

Client Rights/Consent for Treatment

I agree to participate in therapy and am aware that I have the right to access care and habilitation regardless of age or degree of MH/DD/SA. I have the right to withdraw from services. I understand success of treatment depends on my willingness to participate and on the effort that I put outside of sessions.

If I bring my child, I give consent for them to participate in therapy and understand that it is my duty to participate in child's treatment and follow recommendations. I understand that in treating minors, Pamlico River Behavioral Health does not perform child custody evaluations or testimonies in court proceedings.

Privacy/ HIPPA

When we evaluate, diagnose, treat, or refer we collect Protected Health Information about you. We need to use this information to determine what is the best treatment for you. We may also share this with those who also provide treatment for you or pay for the treatment. By signing, you agree to let us use your PHI for the purpose of treating, billing, and business operations, and sending to others with signed consent. This consent is valid for one year and can be withdrawn at any time.

Cultural Competency Policy

We understand the need for our providers to remain culturally and religiously sensitive. If you, as our client, feel that we are not doing so, please notify us, and we will make every attempt to do so, or refer you to a therapist with whom you will feel more comfortable. If you need an interpreter, we will make every effort to secure on or make a referral outside of our office who can provide services in your language. We try at all costs to avoid interpreting by family members and do not allow interpreting by minors.

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Telehealth Informed Consent

Even if you plan to attend in-person, signing this ensures we are prepared if a virtual session is ever needed unexpectedly.

My therapist may need to hold sessions via telehealth. If so, I consent to participate in telehealth sessions as part of my psychotherapy. I understand the telemental health is the practice of clinical health care services via technology between a therapist and a client who are in two different locations.

I understand the following about telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risks, benefits, and consequences associated with telehealth including disruptions by technology failures, interruptions and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any online sessions by either party. All information in sessions and written records are confidential and may not be disclosed to anyone without written permission, except where the disclosure is permitted or required by law.
4) I understand that privacy laws that protect confidentiality of my protected health information also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self/others; I raise mental/emotional health as an issue in legal proceedings.
5) I understand that we can encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we cannot reconnect after ten minutes, please call us at 252-940-1611 to discuss it as we may need to reschedule.
6) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of emergency.

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Financial Policy and Self Pay Rate

Initial Assessment (55 min.)	$150	Phone Consultation/Case Mngmt. (60 min.)	$100
Letters/Reports	$50	*Individual Therapy (55 min.)	$125
Court Appearance Fee (60 min.)	$250	Additional Time (15 minutes)	$20
*Court Appearance Retainer	$500	Crisis/Weekends after 6:00 (15 min.)	$25

*48 hr. notice required to receive full refund 24 hr. notice to receive half refund amount

*See therapist for Sliding Scale

Credit Card Payment Authorization

1) **Phone/Video Sessions:** I authorize my therapist to charge my card at the time of the session or afterwards.
2) **Missed Sessions:** I understand that if I cancel or reschedule without a *24-hour notice*, I authorize my therapist to charge my card on file $35. I also authorize any no call no shows will be charged a $100 fee. If using insurance, the missed session will still be charged for the full amount, not just copayment amount.
3) **Health Savings Accounts (HSA):** If I have an HSA credit card, I authorize my therapist to charge my card for the service at the time of the service or afterwards. I understand that missed sessions NOT be billed to HSA credit cards, nor can I bill sessions in advance on HSA credit cards.
4) **Other Charges:** I understand other charges billed to my credit/debit card are bank fees for bounced checks or any balances not paid withing 30 days.
5) **Other Payment Options:** If I prefer not to use cards, I understand I may pay in advance for sessions by sending a check. However, I understand that a credit/debit card may be charged to cover missed sessions, bounced checks, and unpaid balances.
6) **Credit Card Information:** To comply with the Payment Card Industry Data Security Standards which are designed to prevent data theft and fraud, I understand that my credit/debit card information will NOT be stored in my record. I understand that I will give my credit/debit card information verbally or in writing with registration documents to my therapist and it will be immediately entered into a credit card processing portal which performs data encryption for security.

Signature: _____ Date: _____

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Credit Card Information

Completion of this page is required prior to your appointment, ***regardless of insurance****. We must have a valid card on file for late cancellations or no-shows.*

I agree to allow Pamlico River Behavioral Health to process payments for services using my credit card. *This card will only be charged for fees not covered by insurance, such as no call no shows, late cancelation fees, and copays.* This information will be secure and destroyed once services are terminated. I verify that the credit card information I provide is accurate to the best of my knowledge and understand that I am responsible for the entire amount owed.

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVV: _____

Card Type (Visa, Master Card etc.): _____

*Please note we do NOT accept Discover or Amex.

Signature: _____ Date: _____