(MOUNTAIN CENTER FOR PASTORAL COUNSELING

DIANE STAMEY, M.A.

PATIENT REGISTRATION

Patient's Name_____

Mailing Address_____

City/St./Zip_____

Phone(Home)_____
(Work)_____

(Cell)_____

Birthdate_____Sex_____

Marital Status_____

Social Security #:_____

Employer_____

Employer_____
Address _____

Referred By_____

Name of Nearest Relative_____

RESPONSIBLE PARTY

Name_____

Mailing Address_____

City/St./Zip_____

Phone(Home)_____
(Work)_____

(Cell)_____

Birthdate_____Sex_____

Marital Status_____

Social Security #:_____

Employer_____

Employer_____
Address _____

Emergency Contact_____

Emergency Phone #:_____

PRIMARY INSURANCE COVERAGE

Company Name_____

Policy #:_____Group #:_____

Address _____

City/St./Zip_____

Phone #:_____

Policy Holder_____

Social Security#:_____

AUTHORIZATION

I hereby authorize office personnel to contact me by answering machine or texts to my cell phone for appointment confirmations and other related issues. Also, I hereby authorize the release of any medical information necessary for processing claims.

_____

Signature of Patient (Parental Signature if Patient is a Minor)

PAYMENT IS REQUIRED AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE

SECONDARY INSURANCE COVERAGE

Insurance Co._____

Policy #:_____Group #:_____

Address_____

City/St./Zip_____

Phone #:_____

Policy Holder_____

Social Security#:_____

AUTHORIZATION

I authorize payment of any medical benefits to the provider named herein (Diane Stamey, MA)

_____

Signature of Patient (Parental Signature if Patient is a Minor)

CANCELLATIONS NOT MADE 24 HOURS IN ADVANCE ARE SUBJECT TO FULL CHARGE MONDAY APPOINTMENTS MUST BE CANCELLED BY THE PRECEEDING FRIDAY BY 5:00 P.M., UNLESS THERE IS A TRUE EMERGENCY.

AGREEMENT TO PAY

_____

SIGNATURE

PATIENT FAMILY SHEET
MOUNTAIN CENTER FOR PASTORAL COUNSELING

N. DIANE STAMEY, M.A., M. DIV.
367 DELLWOOD ROAD, SUITE C-3
WAYNESVILLE, NC 28786-3150
828-452-1544 phone 828-452-1285 fax

_____
(TODAY'S DATE)

PATIENT'S
NAME (LAST)_____ (FIRST)_____(MIDDLE)_____
MAILING ADDRESS: _____ PHONE # (HOME)_____
CITY: _____ PHONE# (WORK)_____
STATE/ZIP: _____ PHONE # (CELL)_____
AGE: _____ BIRTHDATE: _____ SOCIAL SECURITY#: _____
EMPLOYER: _____ MARITAL STATUS: _____

IF MINOR LIST PARENTS NAMES: _____

SPOUSE'S NAME: _____ AGE: _____ BIRTHDATE: _____
SPOUSE'S EMPLOYER: _____
SPOUSE'S SOCIAL SECURITY #: _____ WORK PHONE #: _____
NEAREST RELATIVE OR FRIEND: _____ RELATIONSHIP: _____
ADDRESS: _____ PHONE #: _____
CITY/ST./ZIP: _____

NAMES OF CHILDREN	AGE	SCHOOL OR OCCUPATION	WHERE LIVING

OTHERS IN HOUSEHOLD	RELATIONSHIP TO HEAD OF HOUSEHOLD

FAMILY PHYSICIAN OR PEDIATRICIAN_____
MEDICATION PRESENTLY TAKING_____
_____
MEDICAL OR PHYSICAL PROBLEMS_____
_____

DO YOU USE MARIJUANA? DAILY _____ WEEKLY _____ MONTHLY_____

HOW OFTEN TO YOU DRINK? DAILY _____ WEEKLY _____ OCCASIONALLY _____

PATIENT FAMILY SHEET

CHIEF COMPLAINT _____

PERSONAL & FAMILY HEALTH _____

SPECIFIC RECENT CHANGES IN HABITUAL BEHAVOR _____

PREVIOUS PROFESSIONAL COUNSELING _____

HAVE YOU EVER BEEN SEXUALLY ABUSED? _____

ARE YOU ADOPTED? _____

RELIGIOUS PREFERENCE? _____

REFERRAL SOURCE? _____

MOUNTAIN CENTER FOR PASTORAL COUNSELING
N. DIANE STAMEY, M.A., M. DIV.
367 Dellwood Road, Suite C3
Waynesville, NC 28786
dianestameyinc@bellsouth.net
phone- 828-454-1544 fax- 828-452-1285

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____

Date of Birth_____

I hereby Authorize (client or Personal Representative)

_____

Name of Provider /plan _____
To disclose specific health information

From the records of the above-named client to:
(Recipient Name/Address/Phone/Fax)

_____
_____
_____
_____

For 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. I further understand that action taken on this authorization prior to the rescinded date is legal and binding.

AUTHORIZATION OF DISCLOSE HEALTH INFORMATION

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.

_____ (initials required for this section) I understand that by initialing this section, if my record contains information relating to HIV infection, AIDS or AIDS-related condition. By not initialing, such information may not be released. Release of this information occurs in accordance with NCGS 130A-143

_____ (initials required for this section) I understand that by initialing this section, if my record contains information relating to alcohol abuse, drug abuse, or genetic testing this disclosure will include that information. By not initialing this section, such information may not be released. Release of this information occurs in accordance with 42 CFR Part 2.

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 of 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.

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

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

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phone– 828-454-1544 fax 828-452-1285

Effective as of: 09/16/2019

PATIENTS'S RIGHTS

I AGREE THAT I HAVE BEEN SHOWN A COPY OF MY PATIENT'S RIGHTS.

I HAVE READ THEM AND UNDERSTAND.

SIGNATURE_____ **DATE:**_____

I agree in a medical emergency for Nancy Diane Stamey, MA, MDiv to seek Emergency Medical Care from a physician or a hospital.

SIGNATURE: _____**DATE:** _____

I UNDERSTAND I HAVE THE RIGHT TO REFUSE THERAPY SERVICES.

Signature: _____**Date:**_____
Patient Printed Name:_____
Relationship to patient if a minor: _____
Witness:_____**Date:**_____

Authorization to Bill Insurance

Client Name:_____

Policyholders Name(if a minor): _____

Phone: _____

Email:_____

Address:_____

Insurance Company:_____ **Policy Number:**_____

Provider: N.Diane Stamey M.A. , M.Div.; Mountain Center for Pastoral Counseling

Phone: 828-452-1544 **Address:** 367 Dellwood Road Suite C3 Waynesville, NC 28786

I,_____, herby certify and attest that I have sought psychotherapy services from N.Diane Stamey, at Mountain Center for Pastoral Counseling. I therefore authorize the HIPAA certified personnel within the practice to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills pertaining to psychotherapy received.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf, I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims. I understand that I will be responsible for paying all deductibles, fees, co-payments, and other co-insurance payments that may be required.

I understand that any portion of my services that aren't covered by insurance will be billed to me at the address, I have provided above.

Signature:_____ Date:_____

Patient Rights

****Updated September 11, 2019****

Please feel free to take this document, which outlines yours rights as a consumer.

You have:

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy.
2. The right to receive services in the least restrictive, feasible environment.
3. The right to be informed of one's own condition
4. The right to be informed of available program services.
5. **The right to give consent or to refuse any service, treatment or therapy**
6. The right to participate in the development, review and revision of one's own individualized treatment plan, and to receive a copy of it.
7. The right of freedom from unnecessary physical restraint or seclusion unnecessary or unnecessary excessive medication.
8. The right to be informed and the right to refuse any unusual or hazardous treatment procedures.
9. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, or photographs.
10. The right to consult with an independent treatment specialist or legal counsel at one's own expense.
11. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations.
12. The right to have access to one's own client record in accordance with program procedures.
13. The right to be informed of the reason(s) for terminating participation in the program.
14. The right to be informed of the reason(s) for denial of service.
15. The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, sex, national origin, sexual orientation, socio-economic status, disability, or HIV infection (whether asymptomatic or symptomatic) or AIDs.
16. The right to know the cost of services.
17. The right to be informed of all client rights.
18. The right to exercise one's own rights without reprisal.
19. The right to file a grievance in accordance with program procedures.
20. The right to have oral and written instructions concerning the procedure for filing a grievance.

21. The right to participate in consideration of ethical issues that arise in the provision of care and services, including resolving conflicts, withholding resuscitative services, foregoing or withdrawing life sustaining treatment and participation in investigation studies or clinical trials.
22. The right to designate a surrogate decision maker if the individual served is incapable of understanding a proposed treatment or procedure or is unable to communicate his/her wishes regarding care.
23. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments or therapies, or regardless of relapse from earlier treatment in that or another service, unoess there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written in the client's current service plan.
24. The right to a current written individualized service plan that addresses his/her own mental health, physical health, social and economic needs, and that specifies the provisions of appropriate and adequate services, as available either directly or by referral and the right to have a copy of the ISP.
25. The right to individualized treatment, including an adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.
26. The right to care that is considerate and respects the personal values and belief systems of the individual served.
27. The right to have access to his/her own psychiatric, medical, or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. "Clear Treatment Reasons" shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an imminent risk. The personal restricting the information shall explain to the client and other persons authorized by the client the factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing, of the agency's policies and procedures for viewing or obtaining copies of personal record.
28. The right to treatment including access to medical care and habilitation, regardless of ager or degree of MH/IDD/SA disability.
29. The right to exercise any and all rights without reprisal in any form including continual uncompromised access to services.
30. *The right to **EMERGENCY** *services. Providers must provide face-to-face emergency services within two (2) hours after a request for emergency care is received by the provider staff from the PIHP or directly from an Enrollee; the Providers MUST provide face-to-face emergency care immediately for life threatening emergencies.
31. *The right to **URGENT** services. Providers must provide initial face-to-face assessments and/or treatment within forty-eight(48) hours after the date and time a request from urgent care is received by Provider staff from the PIHP or directly from an Enrollee.

32. *The right to **ROUTINE** services. Providers must provide initial face-to-face assessments and/or treatment within fourteen (14) calendar days of the date a request for routine care is received by Provider staff from the PIHP or directly from an Enrollee
33. Patient has the right to be seen within sixty (60) minutes of set appointment.
34. No Walk Ins, Please.
35. *****In the event of an EMERGENCY, Diane Stamey, MA, MDiv may seek Emergency Medical Care from a physician or a hospital.***.**

Disability Rights:

877-235-4210

Governors Advocacy Council for Persons with Disabilities

877-235-4800

NC Department of Health and Human Services

919-855-4800

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

919-715-3197

Diane Stamey

828-452-1544

Updated AR 9-9-19

PATIENT INFORMATION AND OFFICE POLICY STATEMENT

MOUNTAIN CENTER FOR PASTORAL COUNSELING

New Patient: Welcome!

Thank you for choosing my office. I would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Diane Stamey will answer any questions you have regarding any of these policies.

I. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by formulating a proper diagnosis and treatment plan. The treatment plan will focus on: 1. Increasing personal awareness. 2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals, and 3. Promoting wholeness through psychological and spiritual healing and growth.

You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy depends much more on what you do between sessions than on what happens in the session.

I. Appointment:

Appointments are usually scheduled for 45-50 minutes. The practice's hours are Monday 9:00A.M. – Friday 5:00 P.M. Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency, and you are unable to reach your therapist, you may call your primary care physician or the local emergency room. Also Dr. Jim Pruett shares call with Ms. Stamey. You can call him at 704-577-5862.

Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged".
However, there are limits to the privilege of confidentiality. These situations include: 1.) Suspected abuse or neglect of a child, elderly person or a disabled person, 2.) When your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3.) If you report that you intend to physically injure someone, the law requires your therapist to inform that person as well as the legal

authorities, 4.) If your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc. 5.) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6.) In natural disasters whereby protected records may become exposed or 7.) When otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals or to family members.

II. Record Keeping

An electronic medical record is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Active charts are locked and kept on site. Inactive paper charts are locked in another file cabinet.

III. Fees:

Fee for the initial visit, the Diagnostic interview is $165.00 or, as contracted with your Insurance Co. Each 45-55 minute session is $150.00 or as contracted by your insurance company. Most fees are paid by your insurance company up to 80% for each session or a copay.

IV. Payments:

Payment is due at the time of the session unless other arrangements have been made. Your therapist will file your insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefits. If your insurance does not pay, you are responsible for payments. Bills left unpaid for over 60 days without any explanation, will be forwarded to a collection agency. The amount due after 30 days will have a 3% interest charge on the account.

VI: Cancellations and Missed Appointments:

You will be billed for a session that you cancel with less than a 24 hour notice, unless there is a true emergency. Monday appointments need to be cancelled by 5:00 P.M. on the Friday preceding the appointment. You may leave messages 24 hours per a day. You will be billed $50.00, not just a co-payment. Insurance companies will not reimburse for failed appointments. New patients are not excluded. There will be a $50.00 charge for "no show" for new patients.

VII. Consent for Treatment:

I have read and understood this policy statement and I have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to

participate in evaluation or treatment. I understand that I may withdraw from treatment at any time.

VIII. **Emergency Services:**

Providers must provide face-to-face emergency services within two hours after a request for emergency care is received by Provider staff from the PIHP or directly from an Enrollee; the Providers MUST provide face-to-face emergency care immediately for life threatening emergencies.

IX. **Urgent Need Services:**

Providers must provide initial face-to-face assessments and/or treatment within forty-eight (48) hours after the date and time a request for urgent care is received by Provider staff form the PIHP or directly form an Enrollee.

X. **Routine Need Services:**

Providers must provide initial face-to-face assessments and/or treatment within fourteen (14) calendar days of the date a request for routine care is received by Provider staff from the PIHP or directly from an Enrollee.

24 Hour COVERAGE:

After hours you may call my phone at 828-450-3112 OR Dr. James Pruett at 704-577-5862

XI. **Rights and Responsibilities:**

I also acknowledge I have read (and received if requested) a copy of my patient rights and responsibilities.

Name of Patient: _____
(Please Print)

Signature: _____ **Date:** _____

If the Patient is a Minor; Responsible Party Please Print Name and then sign:

Printed Name:

_____

Signature: _____ **Date:** _____