# Azevedo Family Psychology

## Client Information Form

*All fields are required to be completed on this form*

Date: _____/______/______

Client's Name: ________________________________________ Marital Status:__________________

Address: _________________________________________City, State, Zip___________________________

Cell Phone #: (______)________________________ Alt Phone #: (______)________________________

Occupation/Place of Work: ______________________________________________________________

Date of Birth: ______/______/_____ Email: _______________________________________________

Appointment Reminder by ○ Text ○ Email ○ Both ○ Neither

Primary Physician & Phone #: ____________________________________________________________

Client Signature: ________________________________________________________________________

Financially responsible adult for a dependent client is required to complete the following section:

□ Parent or □ Legal Guardian Name: _________________________________________________

Address: _____________________________________________________ DOB ___________________

Cell Phone #: (______)________________________ Alt Phone #: (______)______________________

Occupation/Place of Work: ______________________________________________________________

Date of Birth: ______/______/_____ Email: _______________________________________________

Appointment Reminder by ○ Text ○ Email ○ Both ○ Neither

Parent/Guardian Signature: ______________________________________________________________

# Individual Information Form

## History of Problem

Please describe what brings you into therapy: ____________________

____________________

____________________

____________________

How long has the problem existed: ____________________

____________________

Who else knows about your concerns: ____________________

____________________

What attempts have been made to resolve the problem: ____________________

____________________

____________________

____________________

Any significant family stressors: ____________________

____________________

____________________

____________________

## Personal History

Have you seen a psychologist, psychiatrist, or other counselor in the past? □ Yes □ No
If yes: who, for how long, and in regards to what: ____________________

____________________

____________________

Previous psychiatric diagnoses: ____________________

____________________


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Current medications: ______________________________________________

______________________________________________

Known allergies: ______________________________________________

______________________________________________

Current symptoms (check all that apply):

| | | |
|---|---|---|
| ☐ Sad or unhappy | ☐ Difficulty concentrating | ☐ No pleasure in anything |
| ☐ Tired, no energy | ☐ Suicidal thoughts | ☐ Difficulty sleeping |
| ☐ Sleeping too much | ☐ Lost some appetite | ☐ Eating too much |
| ☐ Tense, anxious, fidgety | ☐ Worried or fearful | ☐ Anxiety or panic attacks |
| ☐ Worry about dying | ☐ Nervous in social events | ☐ Nightmares / flashbacks |
| ☐ Startled easily, jumpy | ☐ Feel numb or detached | ☐ Thoughts stuck in head |
| ☐ Must repeat certain acts | ☐ Need to check & recheck | ☐ Periods of high energy |
| ☐ Unusually irritable/angry | ☐ Unusually revved up | ☐ Periods with less need for sleep |
| Do the above checked symptoms | | |
| ☐ Interfere with work/school | ☐ Interfere with relationships | ☐ Led to drug/alcohol use |

Substance use status:

| | |
|---|---|
| ☐ No history of abuse | ☐ Active abuse |
| ☐ Early Full Remission | ☐ Early Partial Remission |
| ☐ Sustained Full Remission | ☐ Sustained Partial Remission |

Substance treatment history

| | | |
|---|---|---|
| ☐ Inpatient treatment | ☐ Outpatient treatment | ☐ 12-step program |
| ☐ stopped on own | ☐ Other: ______________________ | |

Substances used (check all that apply):

| Substance | Current Use (Y/N) | Frequency | Amount |
|---|---|---|---|
| ☐ Alcohol | | | |
| ☐ Amphetamines | | | |
| ☐ Barbiturates | | | |
| ☐ Caffeine | | | |
| ☐ Cocaine | | | |
| ☐ Crack Cocaine | | | |
| ☐ Hallucinogens | | | |
| ☐ Inhalants | | | |
| ☐ Marijuana | | | |
| ☐ Nicotine | | | |
| ☐ PCP | | | |
| ☐ Prescription: ________________ | | | |
| ☐ Other: ___________ | | | |

Consequences of substance use (check all that apply)

| | | | |
|---|---|---|---|
| ☐ Hangovers | ☐ Withdrawal symptoms | ☐ Sleep disturbance | ☐ Binges |
| ☐ Seizures | ☐ Medical conditions | ☐ Assaults | ☐ Job loss |
| ☐ Blackouts | ☐ Tolerance changes | ☐ Suicidal impulse | ☐ Arrests |
| ☐ Overdose | ☐ Loss of control of amount used | ☐ Relationship conflicts | ☐ |
| ☐ Other: ____________________________________________________________ | | | |

Family history of substance use (check all that apply)

| | | |
|---|---|---|
| ☐ Mother | ☐ Father | ☐ Step-Mother |
| ☐ Step-Father | ☐ Grandmother | ☐ Grandfather |
| ☐ Uncle | ☐ Aunt | ☐ Brother |
| ☐ Sister | ☐ Partner | ☐ Children |
| ☐ Other/Not listed: ____________________________________________________ | | |

## Social/Relational

Current household includes (Check all that apply):

| | | |
|---|---|---|
| ☐ Partner | ☐ Children (#: __________) | ☐ Mother |
| ☐ Father | ☐ Mother-in-law | ☐ Father-in-law |
| ☐ Brother | ☐ Sister | ☐ Brother-in-law |
| ☐ Sister-in-law | ☐ Other: ____________________________________________________ | |

Please describe your relationship with each of the above household members: _____________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Describe your social life: ______________________________________________

______________________________________________________________________

______________________________________________________________________

Describe your home life: ______________________________________________

______________________________________________________________________

______________________________________________________________________

What role does your culture play in your life: ____________________________

______________________________________________________________________

______________________________________________________________________

What role does religion/spirituality play in your life: ______________________

______________________________________________________________________

______________________________________________________________________

What are some hobbies/interests you have: ______________________________

______________________________________________________________________

______________________________________________________________________

Are you currently employed? □ Yes □ No
If yes, what is your current employment situation:
Employer: ___________________________________________________________________
Position: ______________________________ For how long? __________________________
Do you enjoy your work? □ Yes □ No
Is there anything stressful about your current work? _________________________________

______________________________________________________________________________

______________________________________________________________________________

Are you currently in school? □ Yes □ No

| □ High school graduate | □ GED | Year ____________________ |
|---|---|---|
| □ Associates Degree | Year ____________________ | Major ____________________ |
| □ Undergraduate Degree | Year ____________________ | Major ____________________ |
| □ Graduate Degree | Year ____________________ | Major ____________________ |
| □ Other _________ | Year ____________________ | Major ____________________ |

Have you ever been convicted of a misdemeanor or felony? □ Yes □ No
If yes, please explain ____________________________________________________________

______________________________________________________________________________

Are you currently involved in any divorce or child custody proceedings? □ Yes □ No
If yes, please explain ____________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please include any other information you feel is important ___________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________


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# Family History

Maternal History:

Mother's Name: ______________________________________________

Age: ______________ ☐Living Independently ☐Assisted Living ☐Hospice ☐Deceased

Significant medical problems: ______________________________________

______________________________________________________________

Serious illnesses, accidents, or surgeries in the past: ______________________

______________________________________________________________

______________________________________________________________

History of alcohol/drug use: ☐yes ☐no If yes, please elaborate: ________________

______________________________________________________________

______________________________________________________________

History of arrest: ☐yes ☐no If yes, please elaborate: ______________________

______________________________________________________________

______________________________________________________________

Paternal History:

Father's Name: ______________________________________________

Age: ______________ ☐Living Independently ☐Assisted Living ☐Hospice ☐Deceased

Significant medical problems: ______________________________________

______________________________________________________________

Serious illnesses, accidents, or surgeries in the past: ______________________

______________________________________________________________

______________________________________________________________

History of alcohol/drug use: ☐yes ☐no If yes, please elaborate: ___________________________

______________________________________________________________________________

______________________________________________________________________________

History of arrest: ☐yes ☐no If yes, please elaborate: _______________________________________

______________________________________________________________________________

______________________________________________________________________________

Please list any significant illness, accidents, medical problems, or substance use among any siblings or other family members not listed: ___________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

# Signature on File

Client's Name: ______________________________________________________________

Subscriber/Policy Holder's Name: _____________________________________________

Relationship to Client: _______________________________________________________

- I have read and understand the Notice of Policies and Procedures for Azevedo Family Psychology.
- I understand and agree that my insurance is an agreement between my insurance company and me.
- I also understand that I am responsible for any balance regardless of my benefits through insurance.
- I understand and agree that I am responsible for the payment of any and all charges I incur with Azevedo Family Psychology.
- I authorize the release of my medical information to my insurance company should they request such information.
- I hereby authorize that any insurance payments be paid directly to the subscriber/policy holder, as mentioned above.

☐ We have implemented a policy which enables you to maintain your credit card information securely on file with Azevedo Family Psychology. If you choose to this box you are agreeing to the following policy:

> In providing us with your credit card information, you are giving Azevedo Family Psychology permission to automatically charge your credit card on file for your [or any other patient(s) you have listed on this form] outstanding balance/s. Outstanding Balance is the balance owed at the time of service and will be collected then. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. This card will only be authorized for the use of the credit card holder or any person(s) listed above by the credit card holder. This agreement will expire one year after the date listed below. The cardholder may also revoke this consent at any time in writing.

Client Signature: _____________________________________________ Date: ____/____/______

(If client is under the age of 18)
Parent/Legal Guardian Signature: __________________________________ Date: ___/____/____


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# Insurance Information Form

Client Name: ________________________________________________ Date: ____/____/______

**Policy Holder's Information**
Primary Insurance Company: _______________________________________________________________

Subscriber/Policy Holder's Name: _________________________Subscriber's Phone ________________

Client's Relationship to Subscriber/Policy Holder: ____________________________________________

Subscriber/Identification Policy #: _________________________________________________________

Group #: _______________________________________________ Effective Date: ______/_____/_____

Policy Holder's Date of Birth: _____/_____/______ Policy Holder's Employer: ________________________

**Please choose one of the following options:**

- I want Azevedo Family Psychology to assist in filing my insurance claim using the "out of network" options. I authorize Azevedo Family Psychology to communicate with my insurance provider regarding treatment. I understand that Azevedo Family Psychology will follow HIPAA Compliance guidelines regarding my confidentiality and only provide the necessary information requested by my insurance provider. **I understand that if I am 18 years or older, Azevedo Family Psychology reserves the right to speak with the policy holder/guardian about any insurance issues.**

- I do not want Azevedo Family Psychology's assistance with filing my insurance claims.

By signing below, I acknowledge that I have read and fully understand Azevedo Family Psychology's Insurance Fact Sheet. I understand that my individual insurance policy is a contract between the insurance company and myself, and Azevedo Family Psychology is not a part of that contract. I understand that not all services may be covered by my policy. By presenting for care I agree that I am responsible for all services and charges, regardless of my insurance status. Azevedo Family Psychology will not alter my claim, change my diagnosis, or report a different service than what was performed in order for my insurance to cover the charge.

Client Name: ___________________________________________________ Date: _____/_____/______

Client Signature: ______________________________________________________________________

*If client is under the age of 18*

Parent/Guardian Name: _________________________________________ Date: _____/____/______

Parent/Guardian Signature: ______________________________________________________________


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# Insurance Information Sheet

**To ensure prompt correspondence from insurance companies clients should:**

- Call their insurance company to set up preauthorization for services.
- Inform Azevedo Family Psychology on the status of claims in a timely manner
- Keep up with the number of visits and what insurance has authorized.

**Azevedo Family Psychology is an Out-Of-Network company:**

- We will courtesy file to insurance on your behalf within 3-5 business days.
- We will only file to a primary insurance company.

**Resources:**

- 1-800 number on the back of your insurance card
- Dr. Don Azevedo, PhD. (919) 624-9561, Azevedo@afpsych.com
- Commonly used procedure (CPT) codes:
- 90791: Initial Intake Evaluation
- 90834: Individual or Family Therapy Session, lasting 45-50 minutes

# Notice of Policies and Practices (NPP) to protect the Privacy of your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO IT. **PLEASE REVIEW CAREFULLY AND KEEP A COPY FOR YOUR RECORDS.**

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- **PHI** refers to information in your health record that could identify you
- Treatment, Payment and Health Care Operations
  - **Treatment**: is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - **Payment**: is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - **Health Care Operations**: are the activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and care coordination.
- **Use** applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information
- **Disclosure** applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of those listed above when appropriate authorization is obtained. An **authorization** is written permission beyond the general consent permitting specific disclosures. In instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing information. We will also need to obtain an authorization before releasing your psychotherapy notes. **Psychotherapy Notes** are notes your therapist has made about your conversation during any counseling session, which has been kept separate from the rest of your medical record. These notes are given a greater degree of protection that PHI.

The laws and standards of the helping profession require that we keep PHI about you in your medical records. Except in circumstances that involve danger to yourself and/or others, or the record makes reference to another person and we believe that access is likely to cause harm to such other person, you may examine and/or receive a copy of your medical record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence or have them forwarded to another professional so you can discuss the contents. We charge a copying fee per page. If we refuse your request for access to records you have a right of review, which we will discuss with you upon request.

You should be aware that our practice includes multiple mental health professionals and administrative staff. PHI is shared with these individuals for both clinical and administrative purposes, such as scheduling, billing,


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and quality assurance. All of the professionals and staff members are bound by the same rules of confidentiality.

You may revoke all authorizations at any time, provided each revocation is in writing. You may **not** revoke an authorization if 1. We have relied on this authorization, or 2. The authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: if you give us information that leads us to suspect child abuse, neglect, or death due to maltreatment, we must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, we must do so.

- **Adult and Domestic Abuse:** if information you provide gives us reasonable cause to believe that dependent adult is in need of protective services, we must report this to the Director of Social Services.

- **Health Oversight:** The North Carolina Psychology Board has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.

- **Judicial or Administrative Proceedings:** if you are involved in a court proceeding and we receive a court order concerning the services we provided you, we are required to provide such information. If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

- **Serious Threat to Health or Safety:** we may disclose your confidential information to protect you or others from a serious threat of harm by you. If we believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim (if identifiable), and/or calling the police.

- **Worker's Compensation:** if you file a worker's compensation claim, we are required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.

If such a situation arises, we will make every effort to fully discuss it with you prior to taking action and will limit disclosure to what is necessary. While this summary of exceptions to confidentiality should provide helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

IV. Patient Rights and Therapist's Duties

**Patient's Rights**

- **Right to Request Restrictions**- you have the right to request restrictions on certain uses and disclosures of PHI about you. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations**- you have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing a therapist. Upon request, we will send your bills to another address.

- **Right to Inspect and Copy**- you have the right to inspect and/or obtain a copy of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend**- you have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting**- you generally have the right to receive an accounting of disclosures of PHI for which you have neither provide consent nor authorization. On your request, we will discuss with you the details of the accounting process.
- **Right to a Paper Copy**- you have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.
- **Minors and Parents**- While privacy in therapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information be shared with parents. It is our policy not to provide treatment to a child under **12** unless they agree that we can share whatever information we consider necessary with their parents. For children **13 and over**, we request an agreement between the client and their parents allowing us to share general information about the progress of the child's treatment and their attendance at sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections they may have.

**Therapist's Duties**

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post such changes in the office and will provide paper copies of changes upon request.

If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, please discuss this with your therapist. If you would like, you may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

**Financial Agreement**

To provide the best care, it is important that our clients have a clear understanding of our Financial Policy and Fees. We are committed to providing the best possible care and will be happy to answer any questions you have.

-**Professional Fees:** Please refer to the fee schedule as our fees vary depending on the service being provided. We reserve the right to change fees at any time; however you will be notified before such a change occurs. The hourly cost will be broken down for periods of less than one hour. Please be aware that you can be charged for other services including but not limited to: report writing, phone conversations more than 10 minutes, consulting with other professionals with your permission, emergency after-hour face-to-face or phone consultations, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time, including preparation and transportation

costs, even if another party calls us to testify. Please see the fee schedule for costs related to preparation and attendance at legal proceedings.

-**Current Primary Insurance:** In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. Azevedo Family Psychology is an out of network provider. This means ***payment is due in full at the time of service.*** If you have a health insurance policy, it will usually provide out-of-network coverage. We will fill out forms and provide you with whatever assistance we can in helping you receive benefits to which you are entitled. We can only courtesy file claims to an active and primary insurance company. It is the *client's* responsibility to update us when insurance information changes. We cannot back file to any insurance company. It is important to note that insurance companies do not provide reimbursement for missed sessions or telephone contact.

-**Missed or Cancelled Appointments:** Azevedo Family Psychology requires a 24-hour cancellation notice. Clinicians reserve the right to charge up to the full amount of your scheduled appointment. Please see the fee schedule for further information. These fees will *not* be sent to insurance, as they are not covered. The client is responsible for payment in full.

-**Payment for Service:** A $20 administration fee will be added to the balances that are 30 days past due. Payment in full is required at the time of service. Timely payment is important in order to file claims. Accounts with an outstanding balance cannot have claims filed until payment is received. Receipts will not be provided for individual filing for these accounts. If your account has not been paid for more than 60 days and arrangements for payment have not been made, we have the option of using legal means to secure the payment. Any costs associated with this will be included in the claim.

-**Divorced or Separated Parents of Minors:** The parent who brings the child(ren) for the appointment is financially responsible for the appointment(s). Azevedo Family Psychology. will not be involved with separation or divorce disputes pertaining to payment.

**-Responsibility for fees:** You are responsible for payment in a timely manner. Outstanding accounts may be sent to a collections agency. If this should occur, you will be responsible for any fees associated with our contacting and sending the account to collections. Dates of services with an outstanding balance will then no longer be filed to insurance as a courtesy.

Your understanding of these policies is important to our professional relationship. We look forward to answering any of your questions about our financial agreement.

**Client Contract**

This contract contains information about our services and the Health Insurance Portability and Accountability Act (HIPPA). HIPPA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) use for the purpose of treatment, payment, and health care operations. A Notice of Privacy Practices (NPP) that explains HIPPA in greater detail is covered in this document. The law requires we obtain your signature acknowledging that we provided you with this information. Signing this agreement also represents an agreement between us. You may revoke this contract in writing at any time which will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process claims; or if you have not satisfied any financial obligations you have incurred.

**Psychological Services**

When you call to make an appointment with us, a 50-minute initial visit will be scheduled. You will be asked to fill out the required forms and arrive at least 10 minutes early to your appointment to ensure all paperwork is properly completed. The first session will involve an evaluation of your needs. By the end of the

evaluation, we will be able to offer you some information of what our work will include and a treatment plan. You should evaluate this information along with your own opinions of whether you feel comfortable working with Azevedo Family Psychology. If you have questions about our procedures, we should discuss them whenever they arise in order to best serve your needs.

**Contacting Your Therapist**

Due to the work schedule, therapists are often not immediately available by telephone. When unavailable, telephones are answered by voicemail. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave times when you are available. If you are unable to reach your therapist and feel that you cannot wait for him or her to return your call, contact your family physician, or the nearest emergency room and ask for the Mental Health Professional on call.

Please feel free to direct any questions to your therapist. Your understanding of this contract is important to us and we are happy to discuss any or all of these conditions with you at any time. We look forward to serving you and your family. (Rev. 6/16)


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