ELAINE BURGWYN, Ph.D.

Hope Valley Psychotherapy Associates, LLP
(An Office Space Sharing Arrangement)
1502 West NC Highway 54, Suite 603
Durham, NC 27707
(919)-419-3110 ext. 112

Lake Boone Counseling & Psychological Services, LLP
(An Office Space Sharing Arrangement)
3921 Sunset Ridge Rd, Suite 307
Raleigh, NC 27607
(919) 783-7494 ext. 112

INFORMATION SHEET

NAME_____**DATE**_____
FIRST INITIAL LAST NICK NAME

STREET ADDRESS_____**CITY**_____**ZIP**_____

HOME PHONE_____**WORK PHONE**_____**CELL PHONE**_____

PERSONAL EMAIL_____**BIRTH DATE**_____ **SOCIAL SECURITY #**_____

MARITAL STATUS_____**DATES MARRIAGE/DIVORCE**_____

EMPLOYER_____**JOB TITLE**_____ **EDUCATION**_____

SPOUSE_____
NAME DATE OF BIRTH EMPLOYER WORK PHONE

NAME, BIRTH DATE, GENDER & RELATIONSHIP OF CHILDREN & OTHERS_____

_____

_____

MAJOR CONCERNS :(precipitating factors) _____

_____

TREATMENT GOALS FOR YOURSELF AND FAMILY _____

_____

RELEVANT ISSUES_____
YOUR'S & FAMILY - LEGAL - MEDICAL - MENTAL ILLNESS - CHEMICAL DEPENDENCY HISTORY

_____

PHYSICIAN _____
NAME PHONE # ADDRESS

HEALTH STATUS & YOUR STRESSES_____

Referred by_____
OR WEBSITE PHONE # ADDRESS

CURRENT OR PRIOR THERAPY? no___ yes_____
THERAPIST NAME AND PHONE #

I have read and fully understand the professional and business policy of ELAINE BURGWYN. I agree to be responsible for all fees accrued while receiving professional services and I voluntarily agree to participate in such services. I also understand that I am required to give 24 hour cancellation notice or I will be charged for the scheduled appointment. I also understand that my insurance plan will not pay for any portion of a missed appointment and I will be responsible for the full fee.

_____ _____ _____
Signature of Client or Responsible Party DATE Witness

Personal checks and cash are accepted for payment. Sorry, I do not accept credit cards at this time.

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1) CONSENT TO TREATMENT

I do ___ do not ___ want my therapist to file my insurance claims and have payments sent directly to him/her. (Please complete insurance information sheet).

I voluntarily agree to participate in psychotherapy.

_____ _____ _____

Signature of Client or Responsible Party DATE Witness

2) HIPAA PRIVACY STATEMENT

I _____ hereby acknowledge that during the initial contact with Dr. Burgwyn we discussed confidentiality and privacy issues. I was shown a written *Notice of Privacy Practices* *DATED APRIL 14, 2003,* which outlined how protected health information will be treated in her practice, and was offered a copy to keep if I wanted one. I was also informed that if I felt my rights had been violated I could complain to Dr. Burgwyn or the Secretary of the Department of Health and Human Services.

By signing this document I am acknowledging that I have

___ been informed about how my privacy and confidentiality will be maintained by Elaine Burgwyn, Ph.D.
___ requested and received a copy of Dr. Burgwyn's *Notice of Privacy Practices*

_____ _____ _____

Signature of Client or Responsible Party DATE Witness

3) BUSINESS POLICY

I have read and understood the business policy dated 4/14/2003 of Elaine Burgwyn, Ph.D.
I agree to be responsible for all fees accrued while receiving professional services and I voluntarily agree to participate in such services. I also understand that I am required to give 24 hour cancellation notice or I will be charged for the scheduled appointment. I also understand that my insurance plan will not pay for any portion of a missed appointment and I will be responsible for the full fee.

_____ _____

Client or Responsible Person Client Name if Different

_____ _____

Witness Date

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INSURANCE INFORMATION

I hereby authorize my insurance company/EAP/managed care company to pay ELAINE BURGWYN directly for benefits due me out of indemnity or as per contract under the terms of my policy. I also hereby authorize ELAINE BURGWYN and my insurance company/EAP/managed care firm to exchange all records, documents and reports necessary to facilitate payment for covered services. Missed sessions and less than 24 hour cancellation of sessions are not covered by insurance and I understand I am responsible to pay for these sessions in full.

_____
Signature of Policy Holder

_____ _____
Client's Name **Signature of Client or Guardian if different**

Name of Policy Holder_____

Address of Policy Holder_____

_____

Work Phone_____ **Home Phone**_____

Relationship of Client to P.H._____ **Date of birth P.H.**_____

ID # of Policy Number_____ **Group #**_____

Insurance Policy # of Policy Holder_____

Name of Insurance Company_____

Name of Managed Care Plan/Company_____

Billing Address_____

Telephone # of Insurance/Managed Care _____

Deductible_____ **Amount Paid this year**_____

Percentage of charges company will pay _____ **or Co-pay**_____

Is pre-certification necessary?_____**Have you called?**_____

Number of sessions/$ amount insurance will pay per year_____

Is Insurance based on Calendar or Fiscal year?_____ **Begin Date**_____

Effective Date (Date first covered)_____

Is there any wait period for pre-existing conditions?_____