Newton Psychotherapy and Consulting, PLLC
Bernard J. Newton, Jr., MSMFT, LPC

Intake Form - Minor Client

Name of client: _____ Today's Date: _____

Client's date-of-birth: _____

Minor Client's Contact Information (if applicable):

Address: _____

Mobile phone: _____ May we leave a message? Yes No | Text? Yes No

Home phone: _____ May we leave a message? Yes No

Work phone: _____ May we leave a message? Yes No

Email: _____

Electronic Communication Consent

It may become useful during the course of treatment to communicate by email, text message, or other electronic methods of communication. Please be aware that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Bernie, there is a chance that a third party may be able to intercept or view those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- people in your home or other environments who can access your electronic device;
- your employer, if you use your work email to communicate with Bernie;
- third parties on the Internet, such as server administrators and others who monitor Internet traffic.

If there are people in your life who you don't want accessing these communications, please talk with Bernie about potential ways to keep your communications safe and confidential.

I consent to allow Bernie to use unsecured ____ **email and/or** ____ **text messaging [*check any that apply*]** to transmit to me protected health information pertaining to scheduling appointments and billing or payments.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Parent/Guardian Signature: _____ Date: _____

Minor Client's Signature: _____ Date: _____

Client's Initials: _____

Current school and grade level (if applicable):

_____

Name and phone number of client's pediatrician or personal physician:

_____

Name and phone number of client's psychiatrist (if applicable):

_____

Please note that though allowed by law, I will not contact client's physician or psychiatrist unless you sign a specific release or unless I believe that a life-threatening emergency dictates such action.

If applicable, please list client's current psychiatric medications with dosage:

_____

_____

If applicable, please list any other current medications or supplements with dosage and purpose:

_____

_____

Has the client ever been hospitalized for a psychiatric issue? (If yes, please explain below.) Yes | No

_____

_____

Does the client have any significant medical issues? (If yes, please explain below.) Yes | No

_____

_____

How did you hear about Newton Psychotherapy ? _____

Client's Initials: _____

Parent/Guardian Information

Parent's Name: _____ Date-of-birth: _____

Address: _____

Mobile phone: _____ May we leave a message? Yes No | Text? Yes No

Home phone: _____ May we leave a message? Yes No

Work phone: _____ May we leave a message? Yes No

Email: _____

Employer & type of employment: _____

Parent's Name: _____ Date-of-birth: _____

Address: _____

Mobile phone: _____ May we leave a message? Yes No | Text? Yes No

Home phone: _____ May we leave a message? Yes No

Work phone: _____ May we leave a message? Yes No

Email: _____

Employer & type of employment: _____

Are the parents married and living in the same house? Yes | No

If not, please describe the current custody arrangement:

Consent

I request and authorize Bernard J. Newton, Jr. to provide evaluative and/or psychotherapeutic services to my minor child named above as the Client. I attest that I am the Client's legal custodial parent or guardian and that I am legally entitled to authorization evaluation and treatment.

Signed: _____ Date: _____

Printed Name: _____ Relationship to Client: _____

Client Initials: _____

Insurance Reimbursement

I am able to file electronic claims with most every insurance company, including those for which I am considered out-of-network. If you would like me to submit medical insurance claims on your behalf for potential in-network (Carolina Behavioral Health Alliance) or out-of-network reimbursement, please provide the following information. (Please see the Client Disclosure document for more information about insurance claim submission and confidentiality.)

Insured's name: _____

Insured's date-of-birth: _____

ID #: _____ Group #: _____

Employer or company name: _____

Plan name: _____

Customer Service Phone #: _____

Provider Service Phone # (if given): _____

Address for submitting claims:

Authorization

I understand that Bernard J. Newton, Jr. is an in-network provider for Carolina Behavioral Health Alliance only. For all other plans, I understand that I am responsible for the full fee at the time of service. I further understand that having Mr. Newton file claims on my behalf does not guarantee I will receive any reimbursement from my insurance plan.

I authorize Mr. Newton to submit medical/psychological information necessary to file insurance claims on my behalf.

Signed: _____ Date: _____

Out-of-Network (sign this section only if instructed by your therapist)
I understand that my therapist is **not** a participating member of my insurance panel and:

- ☐ my out-of-pocket expenses may be up to $_____ per session
- ☐ my therapist will file claims on my behalf, but this does not guarantee reimbursement
- ☐ my therapist will not file claims on my behalf; I will take responsibility for submitting claims
- ☐ I will pay therapist directly $_____ at time of service
- ☐ I will pay therapist directly for all invoices within 15 days of receipt

Signed: _____ Date: _____

Client Initials: _____

Initial Therapy Information

The information you include on this form will not be part of the client's medical record and therefore, will not be subject to HIPAA laws and regulations. Bernard J. Newton, Jr. may transfer information from this form to your medical record as appropriate for diagnosis and treatment planning.

Initial Concerns:

What brings you to seek help at this time? (Please use the back of this page if you need more room to write.)

Please describe any unusually severe stresses or significant events in the life of the client and family during the last year:

Physical and Emotional Health: How much are each of the following areas a problem for the client?

	Not at All	A Little	Somewhat	Considerably	Terribly
Physical illness/problems	0	1	2	3	4
Alcohol abuse	0	1	2	3	4
Drug abuse	0	1	2	3	4
Sleeping problems	0	1	2	3	4
Eating or appetite	0	1	2	3	4
Abuse (physical, emotional or sexual)	0	1	2	3	4
Anxiety	0	1	2	3	4
Depression	0	1	2	3	4
Family conflicts	0	1	2	3	4
Marital conflicts	0	1	2	3	4
Social relationships	0	1	2	3	4
Job or school conflicts	0	1	2	3	4
Sexual problems	0	1	2	3	4
Spiritual/religious	0	1	2	3	4
Legal	0	1	2	3	4

Please describe the client's consumption of alcohol and/or recreational drugs. (Type, frequency, amount)

Religious affiliation or background (if any): _____

Newton Psychotherapy and Consulting, PLLC

Bernard J. Newton, Jr., MSMFT, LPC

Client Disclosure Statement, Informed Consent, and Practice Policies

The therapeutic relationship is unique in that it is highly personal, and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This document outlines some important information about my background and psychotherapy in general, and helps clarify roles, expectations, and agreements in an effort to contribute to a positive experience. **Please read thoroughly.**

Credentials & Memberships

- Masters of Science, Marriage & Family Therapy – Fuller Theological Seminary (2007)
- Licensed Professional Counselor (2009)
- Practicing in the field of psychotherapy since 2006
- Certified Prepare/Enrich Counselor (premarital & marital inventories)
- Certified Sex Addiction Therapist Candidate, IITAP
- Member, LPC Association of North Carolina
- Member, American Counseling Association

My Approach to Counseling

I work with adult individuals, adolescents, couples, and families to cultivate collaborative conversations around a wide variety of life challenges, including anxiety, addiction and recovery, sexuality, depression, marital difficulties, life transitions, spirituality, and more. I take a narrative, family systems, and client-centered approach to symptom relief, emotional pain, and personality change. My counseling practice is influenced by my belief that people can change if they have enough motivation to understand the emotions, thoughts, behaviors, beliefs, and systemic issues which influence their interpersonal dynamics and self-concept. Additionally, I strive to honor the fact that while I have expertise regarding the therapeutic process, each client is the expert on their own life.

My approach is derived from the following schools of psychotherapy: *Narrative* (Anderson, Combs, Freedman, Epston); *Family Systems* (Balswick, Bateson, Berg, Bowen, Haley, Kerr, Madanes, McGoldrick, Minuchin, Satir, Schnarch, Watzlawick); *Psychodynamic* (Bowlby, Erikson, Freud, Whitaker, Winnicott, Yalom); and *Cognitive Behavioral* (Bandura, Beck). These are well-established and researched therapies focusing on one's present and past history, immediate and extended family relationships, intrapsychic and interpersonal dynamics, and habitual and/or self-destructive thoughts, feelings, and beliefs.

I believe you have taken a very positive and courageous step in seeking help. Effective psychotherapy hinges on your continued willingness to engage this process and our collaborative effort to discern appropriate goals and methods to meet those goals. Psychotherapy typically involves regular 45 to 50-minute sessions. These sessions are typically once-a-week, although duration and frequency vary depending on the nature of our work together and your individual needs. Short-term counseling (one to six months) is appropriate when symptom relief is our primary goal. In long-term counseling, understanding the etiology of symptoms in order to address deeper dynamics will be our goal.

Occasionally, change will be easy and swift, but more often it will be slow and deliberate. Your active involvement is essential to changing your thoughts, feelings, and/or behaviors. Observation, discernment, and understanding of thoughts, feelings, behaviors, and beliefs inside and outside of the counseling room are invaluable to our work together; therefore, your work may include homework assignments, journaling, relationship experiments, or other agreed-upon projects. Although therapy often involves a considerable investment of time, energy, and money, the benefits can be substantial in terms of both temporary relief and more enduring change. Together, we will agree on a treatment plan, periodically evaluate our progress, and, if necessary, redesign our treatment plan, goals, and methods.

As with any intervention, there are both benefits and risks associated with psychotherapy. Risks might include experiencing uncomfortable levels of feelings such as sadness, guilt, anxiety, anger,

frustration, depression, or difficulties in relationships. Some changes may lead to what seems to be a worsening of circumstances or even losses. It is impossible to guarantee any specific results regarding your psychotherapy goals; however, I am committed to working collaboratively with you to achieve the best possible outcomes. You have the freedom to withdraw from therapy at any time, and I will advise you if for any reason, in my professional opinion, our work together may no longer be helpful.

Confidentiality

Your active involvement and open disclosure are essential to the therapeutic process; therefore, information you share with me will be kept strictly confidential and will not be disclosed without your written consent. The privacy and confidentiality of our work and your records are a privilege of yours and are protected by state law and my profession's ethical code. As mandated by law, however, limitations of such client-held privilege of confidentiality exist and are itemized below:

- Life-threatening situations involving yourself or others
- Situations in which children, dependent adults, or elderly persons are put at risk (such as by sexual or physical abuse or neglect)
- If a court of law issues a legitimate subpoena
- If a client is in therapy or being treated by order of a court of law; or if information is obtained for the purpose of rendering an expert's report to an attorney

As part of my professional development and in order to provide the highest quality service, I may work with a psychotherapy supervisor or participate in consultations with colleagues. If I need to discuss your treatment with a colleague or supervisor, I will disguise identifying information and not use your name. Otherwise, I will not tell anyone anything about your record with me, including treatment, diagnosis, history, or even that you are a client without your full knowledge and a signed Authorization to Disclose Healthcare Information.

Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy; therefore, if we come across one another outside of the therapy office, I will not acknowledge you first. If you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Please review the HIPAA Notice of Privacy Practices for more information regarding confidentiality.

Health Insurance and Confidentiality of Records

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process claims. If you instruct me to submit claims on your behalf, only the minimum necessary information will be communicated to the carrier; however, this information must include a diagnosis code, which will become part of your record with the insurance company. In this situation, we will agree upon an appropriate diagnosis code together. Unless authorized by you explicitly, the psychotherapy notes (which contain the details and analysis of our sessions) will not be disclosed to your insurance carrier. I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

Minors

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Confidentiality of Electronic Communication

It is very important to be aware that e-mail, mobile phone, and cordless phone communication can be relatively easily accessed by unauthorized people; therefore, the privacy and confidentiality of such communication can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that many servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong address. I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via e-mail or text messaging for issues regarding scheduling or cancellations, I will do so. While I will try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Please notify me at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication methods. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any services to which you would otherwise be entitled.

Explanation of Dual Relationships

The client's concerns and well-being are of the utmost importance to me. Because of the inherently vulnerable position of a client in psychotherapy, the relationship between therapist and client is one that calls for added protection against exploitation. It is with this concern in mind that, as your psychotherapist, I am legally and ethically required to maintain our relationship in a professional manner, avoiding dual relationships that could impair professional judgment or increase the risk of harm. Our relationship may only be a professional one, that of therapist and client. I am prohibited from developing any other kind of relationship with you, such as a business relationship, a social relationship, or a sexual relationship.

Social Media Policy

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Twitter, Instagram, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

Telephone and Emergency Procedures

If you need to contact me between sessions, please leave a message at 336.283.5063, and your call will be returned as soon as possible. I check my messages a few times a day (but never during the nighttime), unless I am out of town. I if am on vacation or have limited availability, I will leave detailed information about my availability on my voicemail message. I check messages less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, please call emergency services (911), or visit your local emergency room and ask for the psychiatrist on call.

Fees & Cancellation Policy

Initial 55-minute intake sessions are $130. My fee for a 45-minute therapy session is $100 for individuals and $120 for couples/families. I participate as an out-of-network provider with most insurance companies, and I'm able to file claims on your behalf. You will be responsible for the full fee at the time of service, and your insurance company will reimburse you directly.

Payment should be made at the time of the office visit unless other arrangements have been agreed upon. You may pay by cash, credit card, or check made payable to NPC or Bernard J. Newton, Jr. All clients will be required to have a current credit or debit card on file, information which is kept securely in my encrypted practice management system. This card can be used for session fees and will be charged for late cancellations, missed appointments, and/or balances related to the denial of an insurance claim.

Since scheduling of an appointment involves the reservation of time specifically for you, a **minimum of 24 hours notice is required for rescheduling or canceling an appointment**. The full session fee will be charged for sessions missed or rescheduled without such notification. Please note that insurance companies do not reimburse for missed sessions.

Telephone conversations longer than ten minutes, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, and so forth, will be charged at a rate of $100/hr (with a minimum of 1/2 hour for report writing), unless indicated and agreed otherwise.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Termination

Ending any relationship can be difficult; therefore, it is important to have a termination process in order to achieve some closure, regardless of the reason for termination. The appropriate length of the termination process depends on the length and intensity of the treatment. Of course, you have the right to terminate treatment at any time; however, I will generally ask you to participate in one or more therapeutic sessions regarding the termination, if you are willing. If I determine that our psychotherapeutic work together is no longer beneficial or not being effectively used, or if you are in default on payment, I may terminate treatment after appropriate discussion with you and a termination process. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

For legal and ethical reasons, I must consider the professional relationship discontinued if you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance.

Complaint Procedures

Keep in mind that our work is focused on your needs; therefore, if you have concerns about the course of therapy or are dissatisfied with any aspect of our work, please let me know immediately. This will make our work more effective and efficient. If you think that you have been treated unfairly or unethically, by me or any other counselors, and cannot resolve this problem with me, you can contact the North Carolina Board of Licensed and Professional Counselors (P.O. Box 77819, Greensboro, NC 27417 | 844.622.3572) for clarification of clients' rights as I have explained them or to lodge a complaint.

If you have any questions, please feel free to ask. Please retain a copy of this document for your records.

BY SIGNING THE INCLUDED SIGNATURE FORM, I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Newton Psychotherapy and Consulting, PLLC

Bernard J. Newton, Jr., MSMFT, LPC

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information according to The Health Insurance Portability and Accountability Act (HIPAA). Please review this Notice carefully and contact your therapist or the contact listed at the end of this Notice if you have any questions.

I. MY PLEDGE REGARDING HEALTH INFORMATION

Trust and confidentiality are cornerstones of an effective psychotherapeutic relationship, and the privacy of your record is protected by North Carolina state law, professional ethics codes, and the policies described in this Notice. In order to provide you with quality care and to comply with certain legal requirements, I create a record of the care and services you receive from me, and I am committed to protecting the health information contained in that record. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the Notice that is currently in effect.

I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, on my website, and according to the policy outlined in Section III.

II. DEFINITIONS

HIPAA regulations divide your record into two categories: protected health information and psychotherapy notes.

A. Protected Health Information (PHI) refers to information created by me, in both electronic and paper form, which can be used to identify you. PHI contains data about your health/condition, the healthcare I provide, and payment for that healthcare.

B. Psychotherapy Notes contain more detailed documentation and analysis of your sessions and are kept separate from your PHI. Psychotherapy notes are not accessible to insurance companies or other third-party reviewers or, in some cases, to the clients themselves. (See Sections IV.D. for more information regarding the use and disclosure of Psychotherapy Notes.)

This document describes how your PHI that is in my possession may be used and disclosed as well as how I will make that information available to you. PHI is **used** when I share, apply, utilize, examine, or analyze information within my practice; PHI is **disclosed** when I release, transfer, give or otherwise reveal it to a third party outside my practice.

III. YOUR RIGHTS

A. **Privacy:** At Newton Psychotherapy and Consulting, PLLC, I safeguard the privacy and security of your protected health information (PHI) according to the guidelines set forth by HIPAA, related federal statutes, professional ethics codes, and North Carolina state regulations.

B. **Minimum Necessary:** With some exceptions, I will not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made.

C. **Further Restrictions:** You may request restrictions on certain uses and disclosures of PHI; however, federal law does not require that I comply with all requests. If I do not agree to your request, I will put those limits in writing.

D. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full:** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operation purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

E. **Access:** Other than Psychotherapy Notes, you generally have the right to inspect or obtain a copy of your PHI that is in my possession as long as that PHI is maintained by me. If I deny you that right, I will give you, in writing, the reasons for that denial and explain your right to have the decision reviewed. I will provide you with a copy of your record or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

F. **Delivery method:** You have the right to ask that your PHI be sent to you at an alternate address or by an alternate method, and I will comply with that request to the extent possible.

G. **Amendment:** You may request, in writing, an amendment of PHI so long as I maintain that PHI in my records; however, I may deny your request. If so, I will provide a denial in writing within 60 days of the request and will explain your right to file a written objection. I will answer your questions concerning the amendment process.

H. **Disclosures:** I will keep track of all instances in which I disclose your PHI without your prior authorization (see Section IV below). You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

I. **Complaints:** You may file a complaint about my privacy practices without retaliation. See Section V below for more information.

J. **Notice:** You will be provided a paper copy of this Notice from me upon request, even if you have received this Notice electronically. If I make significant changes in policies related to this Notice, I will update this Notice and provide a copy to all clients who are active at the time of the relevant changes.

IV. USES AND DISCLOSURES of PROTECTED HEALTH INFORMATION

I may use and disclose your PHI for several reasons. Some of these uses and disclosures require additional prior written authorization, while others do not. Not every use or disclosure in a category will be listed; however, all of the ways I am permitted to use and disclose information will fall within one of the categories.

A. TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Uses and disclosures related to treatment, payment, or healthcare operations do not require your prior written consent. Accordingly, I may use or disclose your PHI to another healthcare professional to provide treatment to you. For example, if a clinician were to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care, disclosures for treatment purposes are not limited to the minimum necessary standard. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.

Your PHI may be used or disclosed to bill and collect payment for services I provide to you. Additionally, it may be used to facilitate the efficient and correct operations of Newton Psychotherapy and Consulting, PLLC.

B. LAWSUITS and DISPUTES

If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other

lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

C. FURTHER DISCLOSURES WHICH DO NOT REQUIRE YOUR AUTHORIZATION

Federal and state law do not require patient consent for the following additional disclosures of PHI:

1. **Child Abuse:** I am expected to report to the local Department of Social Services information that leads me to reasonably suspect child abuse or neglect. I must also comply with a request from the Director of the Department of Social Services to release records relating to a child abuse or neglect investigation.
2. **Dependent Adult or Elder Abuse:** I must report to the local Department of Social Services information that leads me to reasonably suspect that a dependent adult or elder is in need of protective services.
3. **Judicial/Administrative Proceedings:** I must comply with an appropriately-issued court order or subpoena requiring that I release your PHI.
4. **Law Enforcement:** I may disclose PHI for certain law enforcement purposes, including reporting crimes occurring on my premises.
5. **Medical Examiners:** I may disclose PHI to coroners or medical examiners when such individuals are performing duties authorized by law.
6. **Research Purposes:** I may disclose PHI for research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
7. **Serious Threat to Health or Safety**: I may disclose your PHI to protect you or others from a serious threat of harm.
8. **Worker's Compensation:** Under certain circumstances, I may disclose your PHI in connection with a worker's compensation claim that you have filed.
9. **Specific Government Functions:** I may disclose the PHI of military personnel or veterans under certain circumstances. Also, I may disclose PHI in the interest of national security.
10. **Health Oversight Activities:** Certain public health activities or investigations may necessitate the disclosure of PHI.
11. **Health-related Benefits or Services:** I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.
12. **As Required by Law:** There may be other instances where either federal or state law requires that I release your PHI.

D. USES REQUIRING AN AUTHORIZATION

North Carolina state law and professional ethics codes require authorization and consent before most uses and disclosures of PHI; HIPAA regulations do not change this requirement. In signing this Notice, you are providing general consent to care and authorizing the use and disclosure of PHI for the purposes listed in Sections IVA, IVB, and IVC. In many of these instances and in any other situation not described in Sections IVA, IVB, and IVC, I will request your written authorization before using or disclosing any of your PHI.

1. **Psychotherapy Notes:** Any use of disclosure of Psychotherapy Notes requires your authorization unless the use or disclosure is:
    a. For my use in treating you.
    b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
    c. For my use in defending myself in legal proceedings instituted by you.
    d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
    e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the Psychotherapy Notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. **Marketing Purposes:** As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. **Sale of PHI**: As a psychotherapist, I will not sell your PHI in the regular course of my business.

Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to the extent that I have not already taken action based up on the original authorization.

E. USES AND DISCLOSURES REQUIRING YOU TO HAVE THE OPPORTUNITY TO OBJECT

1. **Disclosures to Family, Friends, or Others:** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

V. QUESTIONS

If you have questions about this notice, disagree with a decision I make about access to your PHI or have any concern that I may have compromised your privacy rights, contact Bernard J. Newton, Jr., LPC at 936 W. 4th St., Suite 200, Winston-Salem, NC 27101 or 336.283.5063. You may also file a written complaint with the Secretary of the US Department of Health and Human Services at 200 Independence Ave. SW, Washington, DC 20201.

VI. EFFECTIVE DATE

This notice is in effect as of May 1, 2015.

BY SIGNING THE ENCLOSED SIGNATURE FORM, I AM AFFIRMING THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR NEWTON PSYCHOTHERAPY AND CONSULTING, PLLC.

Newton Psychotherapy and Consulting, PLLC

Bernard J. Newton, Jr., MSMFT, LPC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, have received a copy of the Notice of Privacy Practices for Newton Psychotherapy and Consulting, PLLC.

Printed client name: _____

Printed client name: _____

Signature of client or parent/guardian: _____ Date: _____

Signature of client or parent/guardian: _____ Date: _____

It is your right to refuse to sign this document.

ACKNOWLEDGMENT OF RECEIPT OF CLIENT DISCLOSURE STATEMENT, INFORMED CONSENT, AND PRACTICE POLICIES

I, _____, have read and understand the Client Disclosure Statement, Informed Consent, and Privacy Policies for Newton Psychotherapy and Consulting, PLLC (revised 05/15). I have had an opportunity to ask questions, and I agree to enter a professional psychotherapy relationship with Bernard J. Newton, Jr.

Client name: _____

Client name: _____

Signature of client or parent/guardian: _____ Date: _____

Signature of client or parent/guardian: _____ Date: _____

It is your right to refuse to sign this document.

Bernard J. Newton, Jr., MSMFT, LPC: _____ Date: _____

936 W. 4th St., Suite 200
Winston-Salem, NC 27101
www.newtonpsych.com

336.283.5063 (p)
336.217.8728 (f)
bernie@newtonpsych.com

Electronic Payment Authorization and Policy

I, _____ , authorize Bernard J. Newton, Jr. to keep my signature on file and to charge my credit/debit/HSA/FSA card for services rendered through Newton Psychotherapy and Consulting, PLLC. I authorize Bernard J. Newton, Jr., MS, LPC, to charge my credit/debit/HSA/FSA card using internet-based transaction services and confirm that use of this service does not violate confidentiality.

Charges to this debit/credit/HSA card may include:

- Out-of-pocket expenses for each psychotherapy session
- Missed appointments (full out-of-pocket charge for the scheduled service)
- Appointments cancelled with less than 24 hours notice (full out-of-pocket charge)

If I am using a Health Savings Account (HSA) or Flexible Spending Account (FSA) payment card, I understand that even if my payment goes through and is authorized at the time that Mr. Newton charges my card, there is a possibility that the payment could later be denied. In the event of this happening, I acknowledge that I am responsible for ensuring that full payment is made by other means.

I understand that this agreement will remain valid for the duration of my treatment with Newton Psychotherapy and Consulting, PLLC. I can modify this form or revoke consent at any time through written notice to Newton Psychotherapy and Consulting, PLLC. I agree to notify Bernard J. Newton, Jr. immediately of any change in credit/debit/HSA/FSA card information.

Responsible Billing Party Name: _____
(as shown on card account)

Billing Address (as registered with card account)**:**

_____

_____

Phone Number: _____ **E-mail:** _____

For your security, Bernie will get your card information in person during your first session. If possible, please have the actual card available at that time; if not, please be sure to have access to the card's number, expiration date, and security code (on the back).

_____ _____

Client/Responsible Party Signature **Date**