ASCEND PSYCHOLOGICAL SERVICES, PLLC

Rockwell, NC 28138

Demographic Form

Date_____

Client Name: _____Date of Birth: _____

Preferred Name: _____ **Gender** - *Male Female* **Marital Status** Married Single Other

Parent/Guardian_____ Relationship _____

Parent/Guardian legal custody papers ___YES __ NO Office will need to make copy of for children under age 18- **BRING TO OFFICE**

Mailing Address _____ Phone – Home #_____

City, State Zip Code_____ Mobile #_____

Email Address:_____

Do you want to receive email and/or text for appointment reminders? *YES NO EMAIL TEXT*

Employer _____ Work # _____

Insurance Provider: _____ Insurance Policy #_____

Policy Holder Name: _____ DOB: _____ Insurance phone #_____

Name and Contact Information of referring physician (if any): _____

Reason for today's visit:_____

_____

Psychiatric History: _____

_____

Medical History: _____

_____

Medications: _____

_____

Allergies: _____

_____

Who and Where to send completed Psychological Evaluation

Contact Name _____

Address: _____

_____

_____

Phone: _____

Fax: _____

ASCEND PSYCHOLOGICAL SERVICES, PLLC
110 A East Main Street
P. O. Box 271
Rockwell, NC 28138
Ph: Office - 704-279-0626
Fax: 704-279-0344

Client Rights

- The Confidential handling of records
- Participation in the development of client's treatment plan
- Having an Individualized, written treatment plan within 30 days of admission to Ascend Psychological Services, PLLC
- Having all civil rights, including the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, register and vote, bring civil actions, and marry and get a divorce, unless the exercise of a civil right has been precluded by an unrevoked adjudication of incompetency
- To dignity, humane care, and freedom from mental and physical abuse, neglect, and exploitation
- To treatment, including access to medical care and habilitation, regardless of age or degree of mh/dd/sa disability. To receive necessary treatment for prevention of physical ailments.
- To live as normally as possible while receiving care and treatment and receive age-appropriate treatment for diagnosis. To have opportunities that enable the individual to mature physically, emotional, intellectually, socially, and vocationally to include special education and training in accordance with state and federal law
- To be free for unnecessary medications and for medication not to be used for punishment, discipline, or staff convenience
- Notification that release / disclosure of information may only occur with an authorization or consent unless it is an emergency or for other exceptions as detailed in G.S. or 164.512 of HIPPA
- Right to only release minimum information necessary for coordination of care and services
- Access to a clinician in the case of emergency
- Effective communication while receiving care, treatment, and services, including any complaints about patient care
- The right to consent to or to refuse treatment
- The right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD) to protect and advocate for my rights:

  Phone: 919-856-2195 or 877-235-4210
  Email: info@disabilityrightsnc.org
  Mail: Disability Rights, 3724 Nation Drive, Suite 100, Raleigh, NC 27612
  Fax: 919-856-2244

My signature below verifies that I have read and understand my Client Rights.

_____ _____

Signature Date

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Authorization to Disclose Health Information

Client Name: _____Date of Birth: _____
Client Medical Record #: _____ Client Insurance: _____

I hereby authorize Ascend Psychological Services, PLLC to exchange specific health information from the records of the above named client with

_____

_____

_____

for the specific purpose(s) _____

Specific information to be exchanged: _____

I understand that this authorization will expire on the following date, event, or condition: Client's termination of services with Ascend psychological Services, PLLC,

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* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

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.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. 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 for 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. If treatment is research-related, treatment may be denied if authorization is not given.

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

_____	_____	_____
Signature of Client	Date	Witness (if required)
_____	_____	_____
Signature of Personal Representative	Date	Personal Representative Relationship/Authority

***Note: this authorization was revoked on: _____ _____

Date Signature of Staff

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Outpatient Service Contract

Welcome to Ascend Psychological Services, PLLC. This document contains important information about Ascends professional services and business policies. Please read it carefully and ask any questions you might have. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL EVALUATION

Your reason for today's visit is for a psychological evaluation. This psychological evaluation will include a clinical interview and the use of one or more standardized psychological instruments. This process could take anywhere from an hour or so to one or more days to complete. The duration of testing depends on what you are being tested for. The risks involved with such evaluations are minimal, although some clients and/or guardians might find the process upsetting or stressful. Please understand that you are free to withdraw from the evaluation process at any time. If you chose to discontinue this evaluation, you will not be penalized by Ascend Psychological Services, PLLC. After testing is finished, it usually take 2 to 4 weeks for me to complete your report.

PROFESSIONAL FEES

I charge the standard amount paid by your insurance company for psychological assessments. You will be responsible for paying any costs not covered by your insurance company.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charge an appropriate fee for any professional time spent in responding to information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with the client's written permission, or with permission of the client's legally responsible person. This release is valid for a specified length of time and is subject to revocation by the consenting individual.

I may need to disclose the fact of admission or discharge of a client to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.

Upon request a client shall have access to confidential information in his client record except information that would be injurious to client's physical or mental well-being as determined by the attending clinician. If the attending clinician has refused to provide confidential information to a client, the client may request that the information be sent to a physician or psychologist of the client's choice, and in this event the information shall be so provided.

Except as provided by G. S. 90-21.4(b), upon request the legally responsible person of a client shall have access to confidential information in the client's record; except information that would be injurious to the client's physical or mental well-being as determined by the attending clinician. If the attending clinician has refused to provide confidential information to the legally responsible person, the legally responsible person may request that the information be sent to a physician or psychologist of the legally responsible person' choice, and in this event the information shall be so provided.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings, however, a judge may order my testimony if he or she determines that circumstances demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality can be complex, and I am not an attorney.

CONTACTING ME
My office phone number is 704-279-0626. My office fax number is 704-279-0344.
My cell phone number is 704-202-2056. My email is david@ascendpsy.com
However, I am often not immediately available. For example, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by confidential voicemail. I will make every effort to return you call within 24 hours of when you make it, with exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call contact you family physician or the nearest emergency room and ask for the psychologist (psychiatrist) on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Your signature below also indicates that you have been informed of you client rights.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent (Guardian) Date

_____ _____
Signature of Clinician Date