409 W. Main Street, Suite 110
Washington, NC 27889
Phone: 252-623-2736
Fax: 252-623-2843

15221 Carrollton Boulevard, Suite 207
Carrollton, VA 23314
Phone: 757-238-2165
Fax: 757-238-2167

Patient Registration

Client Name:(First)_____(middle)_____(last)_____

Date of Birth:_____ Sex _____ SSN#_____

Address: (street)_____(city)_____

(state)_____(zip code)_____

Phone: (home)_____ (cell/work)_____

Referred by:_____

Currently seeing another Mental Health provider (Y/N) Select...

Insurance Information

Name and address for person responsible for bill if different from above:_____

_____

Insurance Provider_____

Primary Insurance Policy and Group Number_____

Secondary Insurance Policy and Group Number_____

I authorize Pamlico River Behavioral Health, PLLC to file their services with my insurance

company: (signature)_____(date)_____

Consent

I have read and received HIPPA privacy practices and I consent to the treatment of myself/my child by Pamlico River Behavioral Health, PLLC. I understand that this consent is voluntary and I have the right to refuse treatment at any time.

(Signature)_____(date)_____

In case of emergency, I authorize Pamlico River Behavioral Health, PLLC to obtain emergency medical care for me. In the event of an emergency please contact the relative or friend listed below:

Name: _____ Contact Number_____

Signature_____ Date: _____

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CLIENTS RIGHTS/GRIEVANCES

Client Rights:

- To be seen by a licensed therapist competent in the area of my treatment
- To be treated in a fair and compassionate manner
- To have my time valued
- To be listened to if I have a problem regarding my care
- To have my information maintained in a confidential manner

It is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment.
It is further the policy of this State that each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities. (1973, c. 475, s. 1; c. 1436, ss. 1, 8; 1985, c. 589, s. 2; 1989, c. 625, s. 7; 1997-442, s. 1.)

I understand that if I have a complaint or grievance, I should:

- Speak with one or both of the owners, Dr. Martha Early or Lynn Piersall, either in person, by phone, or email at PRBH@prbhealth.net
- If we are unable to reach a solution to the complaint or grievance, I have the right at any time to contact any of the agencies below:

- State Office of DWI Services: www.ncdhhs.gov/mhddsas/dwi, 3008 Mail Service Center Raleigh, NC 27699-3008 Ph: 919-733-0566 Fax: 919-508-0963
- North Carolina Division of Mental Health / Developmental Disabilities / Substance Abuse Services www.ncdhhs.gov/mhddsas, Advocacy and Customer Service Section: 919-715-3197 DHHS CARE-LINE: 1-800-662-7030 (Voice/Spanish)
- North Carolina Substance Abuse Professional Practice Board www.ncsappb.org P.O. Box 10126 Raleigh, NC 27605 Ph: 919-832-0975 Fax: 919-833-5743
- Disability Rights NC www.disabilityrightsnc.org 2626 Glenwood Avenue, Suite 550, Raleigh, NC, 27608 (877) 235-4210 or (919) 856-2195 Email: info@disabilityrightsnc.org
- North Carolina Social Work Board: www.ncswboard.org, P.O. Box 1043, Asheboro, NC 27204, ph. 336-625-1679

I certify that I have read and understand this Client Rights/Grievances Policy

Client (or parent/Guardian if minor):_____Date:_____

Therapist's signature/credentials: _____Date:_____

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CULTURAL COMPETENCY POLICY

Pamlico River Behavioral Health, PLLC understands the need for our providers to be sensitive to the cultural needs of our clients. If you, as our client, feel that we are not being sensitive to your culture or religious beliefs, please notify us and we will make every attempt to address this, or refer you to a therapist with whom you will feel more comfortable.

If you need an interpreter, we will make every effort to secure one for you or make a referral outside of our office to a provider who can provide services in your language. Unfortunately, we try at all costs to avoid interpreting by family members and do not allow interpreting by minors.

Client Signature: _____ Date: _____

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Consent to Email or Text

Patients may sometimes be contacted through email and/or text messaging by Pamlico River Behavioral Health Psychotherapists or staff. If at any time I provide an email or text message address or phone number at which I may be contacted, I consent to receiving these communications at that email or text address/phone number from Pamlico River Behavioral Health.

_____(Patient Initials) I consent to receive electronic communications from Pamlico River Behavioral Health at the cell phone number provided or any number transferred or forwarded to that number. I also consent to receive electronic communications from Pamlico River Behavioral Health at the email address provided.

I authorize to receive email and/or text messages at the phone number and/or email address provided below.

Signature_____. Name (Please Print)_____

Date_____

Cell Phone Number:	**Email Address:**

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Telehealth Informed Consent

I, _____, hereby consent to participate in telemental health with, _____, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____
and my emergency contact person's name, address, phone: _____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/ guardian_____ Date_____

Signature of therapist_____ Date_____

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Our office requires that a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff will have access to the information.

I_____, authorize Pamlico River Behavioral Health to keep my signature on file and to charge my credit card as outlined above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

Patient Name_____

Cardholder Name_____

Billing Address_____

City_____ State_____ Zip_____

Circle Credit Card Type: Mastercard Visa Select...

Credit Card Number_____

Expiration Date_____ 3 Digit # on Back of Card _____

Cardholder Signature_____

Today's Date_____