Summit Wellness Centers, PLLC

PO Box:
211 Arden, NC 28704

Client Information Survey (Completed by Client)

Date: _____

In order to better serve you, we would appreciate the following information. Please complete this questionnaire as fully and accurately as you can.

Please Print:

Client Name:_____ Sex:_____M _____F

Home Address:_____ Date of Birth:_____Age:_____

_____ Marital Status:_____

_____ Years Married:_____

E-mail Address:_____

(Completing this is an "opt-in" and signifies your comfort with electronic communications from our office regarding appointments or newsletters).

Phone Number (H):_____(cell):_____

(Cell phones are not as secure as land-lines, but often our clients prefer this method of contact. Completing this signifies your comfort with cell phone communications with our office).

May we leave you a message at any of these phone numbers? _____Yes_____No

If no, please specify how you would like us to contact you. _____

_____

List other family members/significant others living in the home:

Name	Age	Relationship to Client

List other children not living in the home:

Work/School

Current Employer/School_____Location_____

If in school or college, Current Grade/Year_____ Highest grade ever completed_____

Please let me know about any goal(s) pertaining to work and/ or school you would like for us to focus on in our work together.

Beliefs

What is your belief about God?

Do you currently attend a church?_____ If so, where?

Family History:

What words would you use to describe the family you grew up in?

Relationships

Please describe your most important relationship(s), and any goal(s) you may have for our work together pertaining to this area of your life.

Today's Appointment

Explain in your own words why you have made this appointment today (your coach will discuss this with you in more detail):

On a scale of 1-10, Please tell me how motivated you are to achieve your goal(s) in coaching.
(1= Unmotivated 10= Very Motivated)

What is your goal(s) of our work together?

What action(s) have you already taken pertaining to these goal(s)?

What do you perceive to be your strengths/abilities that will assist you in the process of achieving your goal(s)?

What personal weaknesses or vulnerabilities may hinder your success? _____

_____

_____

_____

How did you hear about our practice or the specific coach that you are seeing today?_____

_____

_____

*Other information you feel is important that wasn't asked about:_____

_____

_____

Coaching Disclosure Statement

Patty Williams - Certified Life Coach and Independent Contractor with Summit Wellness Centers, PLLC

I am an active member of The American Association of Christian Counselors, through which I carry certifications in Professional Life Coaching, Spiritual Formation Coaching, Christian Counseling, Crisis Management, Opioid Addiction and Recovery, Women's Life Coaching and Grief Counseling. I am not a licensed counselor, social worker or therapist. Coaching does not involve the diagnosis or treatment of mental health disorders. Coaching is not professional therapy and does not serve as a substitute for such. In the event that issues which would be best handled in a therapeutic context, I will refer to appropriately trained professionals.

Life Coaching is a valuable and helpful resource for those who are needing guidance for decision making, life changes, transitions, spiritual growth or moving forward well in relationships. Those who are emotionally and psychologically healthy, but need someone to come alongside them through these situations or circumstances are appropriate for a life coaching relationship.

As a Life Coach I commit to help you in developing a healthy balance in life, to offer support and guidance through positive change, assist in achieving your life goals, explore potential solutions to life's challenges and supporting your spiritual and emotional growth. I consider the Bible to be the final authoritative basis for faith, values and ethics. I commit to uphold the inherent God given worth and dignity of those I serve. Thank you for the opportunity to minister alongside you in your current journey of life.

By agreeing to become a life coaching client you acknowledge this does not involve the diagnosis or treatment of mental health disorders, and is not a substitute for treatment by a licensed professional therapist. Client further agrees to communicate honestly, commit the time and energy to participate in the coaching program and be faithful in attending sessions.

Coaching sessions will be approximately 45-50 minutes in length. The fee for an individual session is $65.00. My preference is a face-to-face session; however, sessions may also be done by telehealth (private phone call, Google Meet, Facetime). Please give a 24-hour notice when a cancellation is necessary. In the event of a no call no show appointment, client will be responsible for the session fee. A no call/no show appointment is defined as a scheduled appointment where client does not show up for appointment, nor have they called or emailed to cancel session.

Additional assessments are occasionally used to help in reaching, identifying or maintaining goals set by the coach and client. In this event it will be discussed in advance, and if additional fees apply it will be fully discussed and agreed upon prior to use.

Client understands and acknowledges that she/he may terminate or discontinue the coaching relationship at any time.

Privacy Statement

Your sessions are completely confidential. No information will be released unless you have authorized me to do so in writing. The exception to the privacy rule is in the case of threat to the safety of yourself, another individual or as requested by law.

Provide the names of individuals that you approve for release of personal information:

_____ _____

_____ _____

Coach/Client Agreement:

This agreement is made between Patty Williams, Certified Life Coach, and

_____, Client. Date: _____

E mail: _____ Phone: _____

I agree to the above statements as presented in regards to my coaching process.

Client Signature: _____

Summit Wellness Centers, PLLC

PO Box:
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Health Insurance Portability Accountability Act (HIPAA)

Client Rights & Therapist Duties

We recognize that you are a coaching client. However, since our office handles Protected Health Information for counseling clients, we request that you read and complete this document.

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them. We

will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. Additionally, we are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim. I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the North Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the North Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment*** - We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** - We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
- ***For Operations*** - We may use and disclose your health information within as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Patient's Rights:

- ***Right to Confidentiality*** - You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am 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.
- ***Right to Inspect and Copy*** - You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** - If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.
- ***Right to a copy of this notice*** - If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.

- ***Right to an Accounting*** - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** - If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.
- ***Right to Choose*** - You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** - You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** - With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

Disclosure to Health Information Exchanges: (For NC State Health Insurance Plans)

This facility participates in the North Carolina Health Information Exchange Network, called NC HealthConnex. which is operated by the North Carolina Health Information Exchange Authority (NC HIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from North Carolina programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthCOnnex not paid for with state funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC Health Connex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthCOnnex are available in our offices and online at NCHealthConnex.gov. You may also contact our Privacy Office at (828)-692-6383. Again, even if you opt out of NC HealthConnex, we will submit your PHI if your health care services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHealthConnex.gov/patients.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Legal Guardian Signature Date

_____ _____

Printed Name

_____

Client/Legal Guardian Signature Date

_____ _____

Printed Name

_____

Kevin Wimbish, LMFT, HIPAA Compliance Officer

Summit Wellness Centers, PLLC
PO Box 211
Arden, NC 28704

Coaching Payment Policy:

It is the policy of Summit Wellness Centers, PLLC that payment is due by the time of service unless other financial arrangements are made in advance. In order to complete this process efficiently, Summit Wellness Centers, PLLC will maintain secure records of our clients' credit /debit card. Your card will be billed for the payment as agreed upon in the Coaching Agreement or on the day of your appointment. Your card will also be charged for no-show appointments on the date of service you were scheduled.

By paying via credit/debit card, you acknowledge that this credit/debit card information will be automatically kept on file via PCI-compliant encrypted code with the following credit card processor: TSYS (CAYAN). Health Savings Account cards can be kept on file as the primary form of payment but there must be a back-up credit/debit card on file in case HSA funds are depleted.

I (we), the undersigned, authorize and request Summit Wellness Centers, PLLC to charge my credit/debit card, indicated above, for balances due for coaching services rendered. In the event of no-show appointments, I authorize Summit Wellness Centers, PLLC to charge my credit/debit card for my balance due. Please remember that you are 100 percent responsible for all charges incurred. This authorization will remain in effect until I(we) cancel this authorization. To cancel, I(we) must give a 60 day notification to Summit Wellness Centers, PLLC in writing and the account must be in good standing. By my signature below, I also indicate my understanding and acknowledgement that coaching is not reimburseable by insurance and I am responsible for the full fee as set forth in the Coaching Agreement.

Cancellation/No-Show Policy:

If for any reason you need to cancel an appointment, you must contact us at least 24 hours prior to the appointment to reschedule. Otherwise, you will be charged for the time that was reserved for you. If you repetitively cancel appointments, we reserve the right to discontinue services. This cancellation and no-show policy assures that we are being good stewards of the number of sessions our coaches can provide and allows us to best serve our clients. We appreciate your cooperation and partnership in this matter as we seek to serve.

Signed Agreement:

I understand and agree to the preceding information regarding the cancellation/no-show policy and the financial requirements/payment policy for services rendered.

Client Name _____ Date _____

Client Signature _____

Coaching Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit www.schedule.care to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: _____

Your email address: _____

Your phone number: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

_____ I am choosing to **Opt In** to communications via the method specified above.

If you would like to **Opt Out** at any time of future communications from our office, please email lbeddingfield@ summitwellnesscenters.com indicating the method of communication from which you would like to opt out.

Appointment information is considered to be "Protected Health Information" under HIPAA. I understand that email and standard SMS messages are not confidential methods of communication, and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my mental/behavioral health care may be intercepted and read by a third party. Accordingly, by my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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Signature Date