Good Thoughts Services, PLLC

Name: _____

Date of Birth: _____

Address: _____

Email: _____

Phone Number: _____

Is it ok to leave a message at this number:_____

Primary Care name, address and phone number:_____

_____

Therapist name, address and phone number: _____

_____

Emergency Contact Name and Phone Number: _____

_____

May I share your mental health information with this person?:_____

Client Signature and date: _____

Please have all medication bottles including supplements available for your first appointment. Also, if you have any lab work from the past 12 months, medical records you would like reviewed, Neuro-Psych Testing Results, ADHD Evaluations, MRI Results, etc. Please email copies to be reviewed prior to your intake appointment. Knowing the names and dosages of your current medications is very important.

List medications and dosages you are currently taking (please include over the counter medications, herbals and any nutritional supplements)
List here:

Do you see any specialist:

If so, Specialist name and phone: _____

Are there any spiritual, ethnic, cultural or other Identities you want me to know about? Please list

Is there anything else you would like me to know, what is your reason for wanting to be treated at this time?

Client Signature and Date: _____

Good Thoughts Services, PLLC

Insurance Provider: _____

Member ID: _____

Group Number: _____

Relationship to the insured subscriber: _____

Patient/Guardian signature on document: _____

Please provide a copy of the front and back of your insurance card.

*The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand I am financially responsible for any balance. I authorize the release of any information required to process claims.

Client Signature:_____

Date: _____

MENTAL HEALTH AND WELLNESS AGREEMENT POLICY AND CONSENT

Welcome to Good Thoughts Services, PLLC

992 Durham Rd., Ste. C

Wake Forest, NC 27613

(919)263-0827

I am Angela Good FNP-C, PMHNP-BC and owner of Good Thoughts Services, PLLC. I appreciate you taking a moment out to read this. I am board certified as a Psychiatric Mental Health Nurse Practitioner (PMHNP) and Family Nurse Practitioner (FNP). I want to thank you for choosing me to provide for your mental health and wellness needs and goals. I appreciate and acknowledge the courage it takes to want to make a change, and I am delighted, honored, and privileged to be working with you through this journey.

Good Thoughts Services, PLLC, is a holistic mental health and wellness private practice that offers treatment modalities such as medication management and therapy sessions. I offer telehealth visits, in-person visits and group visits. I am dedicated to helping individuals explore and heal from things holding them back from reaching their full potential and enjoying life. I partner with clients to help them achieve satisfaction and success.

I very much welcome and appreciate new clients into my practice. Should you have any questions before our meeting, please feel free to give me a call.

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in mental wellness treatment may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in mental wellness treatment can lead to a greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of mental wellness treatment.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is

essential they take medications as prescribed. The journey to mental wellness is a marathon, not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the process, we identify goals, review progress, and modify the treatment plan as needed.

SERVICES: You agree to receive medication management which may involve the off-label use of medications. You understand the risks, benefits and alternatives of receiving these services and have had the opportunity to ask questions. My new patient appointment consists of a thorough evaluation and last one hour, follow up appointments can range from 20-45 minutes depending on complexity of your needs. QbTech testing last approximately 20 minutes (in-person) and labs (cheek swab) take approximately 15-20 minutes.

APPOINTMENTS AND CANCELLATIONS:
In order to provide quality care to my patients and to minimize waiting for appointments, my practice has implemented a uniform policy with regard to missed appointments. Please read the policy carefully, as it will be enforced.

Late Cancellation: Any appointment cancelled less than 24 business hours prior to the scheduled time is considered a late cancellation.

No-Show: A missed appointment of any kind without calling the office to cancel is considered a no-show.

PROCEDURE FOR MISSED APPOINTMENTS:
The same procedure will be followed for late cancellations and no-shows. Please note: this charge is applied at the providers discretion.

If one appointment is missed, you will receive a letter of notification and incur a fee $25.00 for a 30 minute appointment or $45.00 for an hour session. This amount is not covered by insurance, and will need to be paid within 30 days of the missed appointment.

If two appointments are missed, a letter will be mailed to the address on file stating that two appointments have been missed and that my case may be closed. You will be provided with thirty days of medication while securing a new provider. Effective thirty days from the date of the letter, You will not be considered an active patient at Good Thoughts Services, PLLC. No further treatment (appointments, telephone calls, prescription refills, etc.) will be provided.

PHONE CONTACTS AND EMERGENCIES: Office hours are by appointment

only. If you need to contact me for any reason, please call (919)263-0827 leave a voicemail, and a return call will be made as soon as possible (usually within 24 hours). In case of an emergency, you can access emergency assistance by calling 911. The Hope Line text or call at 919-231-4524 or 877-235-4525, providing access to free, 24/7 support and information. If either you or someone else is in danger of being harmed, dial 911or go to your nearest emergency room.

CONFIDENTIALITY

Anything said in mental health and wellness treatment is confidential and may not be revealed to a third party without written authorization, except for the following limitations:

• Child Abuse: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/ abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, we are required by law to report this to the appropriate authority.

• Vulnerable Adult Abuse: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, we are required by law to report this to the appropriate authority.

• Self-Harm: Threats, plans or attempts to harm oneself. We are permitted to take steps to protect the client's safety, which may include disclosure of confidential information. This can include disclosure of information to your emergency contact in order to ensure your safety.

• Harm to Others: Threats regarding harm to another person. If you threaten bodily harm or death to another person, we are required by law to report this to the appropriate authority.

Be aware that:

• Social Media: In a digital modern world we use our professional social media platforms to advocate for mental health and wellness while providing educational information. Social media should not replace mental health and wellness treatment. No friend requests on our social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) if you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. We cannot be held liable if someone identifies you as a client. Please do not contact us through any social media site or platform. They are not confidential and may become part of a medical record.

• Electronic Communication: Any electronic means of communication bears the

risk of being intercepted. Furthermore, if you send email from a work computer, your employer has the legal right to read it. Emails sent to our office are made a part of your medical record, and communication via the secure patient portal is preferred.

Do not email, text, or leave a voicemail if you are experiencing a life-threatening event. Call 911, or go to your nearest emergency room.

INFORMED CONSENT ATTESTATION

1. I have read and understand the information contained in the Mental Health and Wellness Agreement, Policy and Consent. I have discussed any questions that I have regarding this information with my clinician. My signature below indicates that I am voluntarily giving my informed consent to receive Mental Health and Wellness services and agree to abide by the agreement and policies listed in this consent. I authorize Good Thoughts Services, PLLC to provide medication management and counseling services that are considered necessary and advisable.

2.If a "super bill" is requested I authorize the release of treatment and diagnosis information necessary to process "super bills" for services to my insurance company, I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, Good Thoughts Services, PLLC may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

Your signature signifies that you have received a copy of the "Mental Health and Wellness Treatment Agreement, Policies and Consent" for your records.

The **CLIENT MUST** sign the consent if they are able to do so. The only exceptions are if the client is a minor, or has a legal document giving permission for someone else to sign on their behalf.

Date _____

Signature _____

TELEHEALTH CONSENT, POLICY, and AGREEMENT

Laws can require health care service providers to get the consent of patients prior to engagement through telehealth. With this form, I intend to get your consent before you can use
the service by helping by helping you be informed of the benefits and limitations of this method of treatment.

This form is in addition to the regular Mental Health and Wellness, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA.

You **must sign both** in order to participate in Telehealth sessions.

Required Information at Every Visit

Name, location, and telephone number of the patient at time of session. This is to ensure that your practitioner is aware of alternative means of treatment should an emergency occur.

Name, location, and telephone number of the provider at time of session.

Telehealth incorporates HIPPA compliant email, phone and video technology.

Benefits:

The benefits to Telehealth are:
1. The ability to expand your choice of service provider.

2. Improved patient experience by options by reducing the overall cost and time of appointments due to not having to drive to and from an office.

3. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.

4. Increased access to psychiatric care to all including: homebound clients, clients with limited mobility, and clients without convenient transportation options.

Limitations:
It is important to note that there are limitations to Telehealth that can affect the quality of the session(s). These limitations include but are not limited to the

following:

1. Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.

2. Technology might fail before or during the telehealth session. Our second line of communication will be via telephone

3. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.

4. To reduce the effect of these limitations, we may ask you to describe how you are feeling, thinking, and/or acting in more detail than we would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Logistics: When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant platform Spruce. I expect that you are available
at our scheduled time and are prepared, focused and engaged in the session. I am calling you from a private location where I am the only person in the room, you also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others can hear you, I cannot be responsible for protecting your confidentiality.

Every effort **MUST** be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. Please know that I cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.

Please know that per best practices and ethical guidelines I can only practice in the state(s) I am licensed in. That means wherever you permanently reside I must be licensed. You agree to inform
me if your residential location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Video Sessions: If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. If I cannot reach you, I will remain available to you during the entire course of our

scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via. phone or plan an alternate time to complete the remaining minutes of our session.

Connection Loss During Phone Sessions: If we lose our phone connection during our session, I will call you back immediately. Please also attempt to call us at 919-263-0827 if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you 2 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session.

Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked, please be sure to pick it up.

Safety: If I have concerns about your safety at any time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are
located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in Telehealth Sessions: By signing below, you agree that you have read and understand all of the above sections of Telehealth informed consent. You agree that you also understand the limitations associated with participating in Telehealth sessions and consent to attend sessions under the terms described in this document.

The **CLIENT MUST** sign the consent if they are able to do so. The only exceptions are if the client is a minor, or has a legal document giving permission for someone else to sign on their behalf.

Date_____

Signature _____

Good Thoughts Services, PLLC

Financial Policy

Thank you for choosing us as your healthcare provider. I am committed to your privacy and treatment needs. Please understand that payment of your bill is considered a part of your treatment. I require you to read and sign an acknowledgement to this policy prior to any treatment.

PATIENT RESPONSIBILITY
Adult patients are responsible for payments as outlined in this policy at the time of service. The adult accompanying the minor, the parent, and/or the guardians of the minor are responsible for payment due. All patients must complete our insurance form before seeing the provider. Providing us with accurate and current insurance information is your responsibility.

CO-PAYMENT/CO-INSURANCE PAYMENT IS DUE AT TIME OF SERVICE

I ACCEPT CASH, CREDIT, AND CHECKS MADE OUT DIRECTLY TO THE PROVIDER OR SUPERVISING PROVIDER WHEN NECESSARY.

PAYMENT ARRANGEMENTS FOR SELF PAY, WILL BE DISCUSSED WITH THE PROVIDER IN SESSION ONLY AFTER THE ORIGINAL APPOINTMENT HAS BEEN PAID IN FULL.

INSURANCE
Please be aware that some, and perhaps all, of the services provided may be non-covered services under the Medicare Part B or other health insurances. We will do our best to inform you on any
non-covered services prior to your visit; however, you may still be responsible for payment in full for those services.

If we do NOT participate with your insurance company, full payment is due at the time of service. For insurance plans we participate with, we will submit your claim to your insurance company. All co-pays and deductibles are due at the time of service. In the event there are multiple insurers responsible, we will

follow any legal, insurance plan outlined, or customary orders of priority in which we bill your insurance carriers.

CASH PAY FEE SCHEDULE
New Patient Evaluation $200-$250. QbTech Testing: $200
Follow- Up Evaluations $150
Telephone Calls 5-10 min $20
Telephone Calls 11-20 min $40
Telephone Calls 21-30 min $60
Forms / Letters - $ 50
Balances Due Greater than 60 Days - $25 additional fee

TELEBEHAVIORAL HEALTH
Some providers participate in telebehavioral health services, that is, psychiatric and/or therapy services using real-time interactive audio and visual electronic systems (i.e. phone or video communication) in which the services provider and the patient are not in the same physical location.

Please be aware that some, or all, of these services may be non-covered under different health insurances. We will do our best to inform you of any non-covered services prior to your visit; however, you may still be responsible for payment in full for services not covered by your insurances.

COLLECTIONS
I will provide statement of balances due for non-covered benefits, deductible, and or amounts due. I reserve the right to utilize a collection agency when any account has been deemed in default or noncompliant with my policy. Once submitted to collections, you will need to contact the contracted collections agency for settlement and or payment. Please be aware that payment arrangements can be made with the provider, however this would for the past due amount, and conditional to maintain any further treatment costs.

PAPERWORK/DOCUMENTATION
Any requests for forms to be filled out by your provider or documentation needed for use outside of this office will be assessed a $50.00-$150.00 fee (dependent on the complexity of the paperwork
and time to complete). This fee is not negotiable and will be collected prior to return of the completed paperwork. In some cases, I may need you to schedule an appointment to discuss what is to be documented but please be aware that the $50.00-$150.00 will still be assessed.

MISSED, CANCELLED, OR RESCHEDULED APPOINTMENTS
Please help me serve you better by keeping scheduled appointments. If you

accumulate more than 2 missed appointments, it may result in dismissal from the practice. I require a 24-hour notice to cancel or reschedule an appointment. Your account will be charged $25.00 for a 30 minute appointment or $45.00 for an hour session. This amount is not covered by insurance, and will need to be paid within 30 days of the missed appointment.

By signing this document, I acknowledge I have read the Financial Policy. I understand and agree to any and all terms.

The **CLIENT MUST** sign the consent if they are able to do so. The only exceptions are if the client is a minor, or has a legal document giving permission for someone else to sign on their behalf.

Client Signature: _____

Date: _____

Credit Card on File Consent

Information to be Completed by Cardholder:

The undersigned agrees and authorizes Good Thoughts Services, PLLC to save the credit card on file as entered into this document or into my electronic health record.

I authorize Good Thoughts Services, PLLC to process the credit card as “Card on File”. I understand this authorization will remain in effect until the expiration of the credit card account in which it will be updated. Clients may also revoke this form by submitting a written request to Good Thoughts Services, PLLC at the address above. If a charge is processed to the card of file and declined, the client will be billed for any fee(s) associated with the decline of the credit card.

I understand that if the invoice sent to me prior to my appointment is not paid 24-hrs before my appointment, Good Thoughts Services, PLLC will charge the amount due to my credit card on file.

I further understand that if there is a balance due after my insurance pays for my visit, my credit card on file will be charged for that balance without prior notification. This is not “balance billing,” balance due would be considered the patient responsibility noted on your Explanation of Benefits from your insurance company.

I acknowledge that I am an authorized user on the card being used, or I have been given permission to utilize such card. If a fraudulent accusation results as a result from using this card, Good Thoughts Services, PLLC will cooperate with the authorities to prosecute any illegal activity. Please make sure you have permission of the cardholder to use the credit card on file.

The **CLIENT MUST** sign the consent if they are able to do so. The only exceptions are if the client is a minor, or has a legal document giving permission for someone else to sign on their behalf.

Client Signature: _____

Date: _____