Asheville Integrated Behavioral Health, PC

30 Clayton Street, Asheville, NC 28801
Ph: 828-423-0537; Fax: 828-333-4362
whamiltonphd@behealthavl.com

BACKGROUND INFORMATION FORM

Please provide the following information about yourself. What you write is confidential. It will help me to understand your situation better when we first meet.

Full Name _____ Date of Birth: _____/_____/_____
Address:
_____ Gender:_____
_____
_____ Age:_____

Best phone: (_____) _____ -_____ Education Level: _____
Can I leave a voice message on this number? Y/N

Occupation:_____

Email _____

Marital Status:_____

Would you like appointment reminders via (circle) Text/Email/None
[*Please note that exchanging texts, emails, or other forms of digital communications with Dr. Hamilton indicates that you voluntarily waive confidentiality protections from that medium, as your device cannot be assumed to be secure]*

Person Dr. Hamilton may contact in case of an emergency:

Name:_____ Telephone:_____
Please list names and ages of family members and circle whom you presently live with:

_____

_____

In your own words, please describe why you are being evaluated/seeking treatment:

_____

_____

Who were you referred to this office by? _____
Please list all medications, including vitamins/supplements you are currently taking:

MEDICATION	DOSAGE	DESIRED EFFECT

Do you smoke or use other tobacco products? Yes No
Do you drink two or more coffees, teas, or caffeinated sodas per day? Yes No
Do you drink more than two alcoholic beverages per week? Yes No
Do you use other recreational substances? Yes No
Do you exercise at least twice a week? Yes No
Please rate your sleep quality 0 (very poor) – 9 (excellent) _____

Please Continue On The Next Page~~~

What are some examples of behaviors you are interested in changing?

_____

_____

How willing are you to attempt changes to these behaviors? 0 (not) – 9 (very)_____

Below is a list of diseases and symptoms that you may have experienced. Please circle all that apply to you.

Auto-Immune Disease	Coma	HIV/AIDS	Paralysis
Alcoholism	Depression	Hormone Diff.	Polio
Anxiety	Diabetes	Hypertension	Rheumatic fever
Arteriosclerosis	Dizziness	High Cholesterol	Seizure/Epilepsy
Arthritis/Gout	Drug Addiction	Hypoxia	Sensory Loss
Asthma	Encephalitis	Kidney Disease	Sleep Apnea
Attention Deficit	Fibromyalgia	Liver Disease	Stroke/TIAs
Blood Disease	Food Intolerance	Loss of Smell	Syphilis
Brain Tumor	GI Issues	Memory Loss	Thyroid Disease
Cancer	Head Injury	Meningitis	Tourette's
Chemical Exp	Headaches	Migraines	Tremor
Chronic Fatigue	Heart/Lung Disease	Multiple Sclerosis	Vit D Deficiency
Chronic Pain	Heat Exhaustion	Numbness	Unconsciousness
		Parkinson's	

Please Describe Any Other Medical or Psychiatric Conditions You May Have:

_____

_____

What is your surgical history? (procedure/approximate year)

_____

_____

What major medical/psychiatric conditions have your family members had? (e.g. dementia, psychosis, etc).

_____

_____

In the past two weeks, have you been sad most or days and/or less interested in doing things you used to enjoy? Yes No

Have you felt sad or depressed most days for the past two years? Yes No

Have you ever had a sudden episode where you felt remarkably anxious, scared, or nervous, felt you might die, or other symptoms of panic? Yes No

In the past month, have you avoided social situations due to fear of embarrassment, humiliation, or shyness? Yes No

Do you repetitive or recurrent unwanted thoughts or impulses (e.g. fear of harming others or contamination, collecting, unwanted sexual imagery, etc)? Yes No

Have you ever experienced a traumatic event in which the life or physical integrity of yourself or someone close to you was threatened (e.g. assaults, accidents, abuse, etc)? Yes No

Do you have pain that has persisted longer than three months? Yes No

Are you very concerned about your body image? Yes No

In the past month, have you thought about suicide? Yes No

Have you ever made a suicide attempt? Yes No

Have you ever been psychiatrically hospitalized? Yes No

Have you ever previously participated in psychotherapy? Yes No

Please Continue On The Next Page~~~

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DISCLOSURE

By completing and signing this intake form, I am consenting to a psychological or neuropsychological evaluation and, if appropriate, treatment by William Hamilton, PhD. I understand that behavioral psychotherapy and biofeedback may not necessarily be effective for my treatment goals and that any form of psychological treatment entails risk, including (but not limited to) boredom, guilt, shame, frustration, emotional distress, not completing my treatment goals, or the onset of new psychiatric symptoms. Further, I acknowledge that psychological treatment generally requires active participation, including attempting new behaviors, enduring distress, and willingness to change beliefs about myself or others. However, the anticipated benefits of therapy often include increased sense of well-being, improved relationships, healthier behaviors, and better problem-solving skills. The typical course of therapy varies depending on what symptoms I have and what my treatment goals are, although a standard course of treatment may involve 8-20 weekly sessions and may include follow-up maintenance care. I can withdraw from treatment at any time for any reason, although I will not likely gain all the benefits from treatment by doing so. Dr. Hamilton may also terminate treatment with me if it does not appear out treatment will be effective or for non-payment of services, but he will provide alternate treatment recommendations in this unlikely event. I also further acknowledge Dr. Hamilton may be unavailable to provide emergency psychiatric services, but that I may contact my local emergency department/911 if a psychiatric emergency arises.

Dr. Hamilton will keep confidential records of my care (including using reasonable safeguards against electronic security breaches), and I have the right to: request a copy of my record, request amendments to the record, receive an accounting of most authorized or unauthorized disclosures of my record (by telephone or in person, or in writing by my request), to record complaints about services in my record, and to receive paper copies of clinic policies. My personal health information (PHI) will not be shared with anyone else without my written permission (except in the rare circumstances such as where a person's safety is endangered, under court order, or under execution of Dr. Hamilton's professional will, as detailed in the Notice of Privacy Practices). As Dr. Hamilton cannot guarantee the confidentiality of sensitive health information using digital forms of communication (texts, unencrypted emails, Skype, social media, etc.), I acknowledge that Dr. Hamilton will generally not respond using these types of communication (except, in some cases, for simple changes to appointment times). Further, if I elect to contact Dr. Hamilton using unsecured forms of electronic communication, I am electively waiving my confidentiality rights for that specific medium/communication, although I may use the Spruce Health App if I wish to communicate securely.

I hereby **authorize/decline** (circle one) my insurance provider _____/ID#_____ to pay for Dr. Hamilton's services, although I am ultimately responsible for the fees associated with each of my sessions. I am aware that my contract with my health insurance company may require Dr. Hamilton to provide it with information relevant to the services being provided, including clinical diagnoses, additional clinical information such as treatment plans or summaries, or copies of my entire clinical record. I authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me to release any such information needed to determine benefits payable for related services. In the event of an unpaid bill exceeding sixty days, I acknowledge that Dr. Hamilton may attempt to work with me to develop a payment plan or cease treatment until the outstanding balance is resolved. Further, credit cards used to pay for services will be securely kept on file for future payments, unless requested otherwise.

I am ultimately responsible for the fees associated with each of my sessions with Dr. Hamilton, which include:

- $165 for a 60 to 90-minute intake assessment
- $150 per 55-minute individual/couples psychotherapy session; $50 per additional 15 minutes
- $100 per 40-minute individual/couples psychotherapy session
- $150 per hour of neuropsychological/psychological assessment
- $50 for first 10-30 minute telephone consultation, $50 per additional 15 minutes (occasionally not covered by insurance)
- $300 per hour of courtroom appearance (with a minimum charge of $2400) (not covered by insurance)
- $50 per half hour of additional paperwork- treatment summaries, disability forms, etc. (often not covered by insurance)
- $25 fee for returned checks; standard NC fees for records copies over 10 pages
- **$50 in each instance where I no show/cancel less than 24 hours in advance of an appointment**

Further, I acknowledge receiving a copy of the form entitled "NORTH CAROLINA NOTICE FORM" (Privacy Practices) and have been given the opportunity to discuss any questions I may have regarding privacy practices consistent with HIPPA regulations.

Signature Name DOB Date

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NORTH CAROLINA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS I NFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "**PHI**" refers to information in your health record that could identify you.
- "**Treatment, Payment and Health Care Operations**"
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician, psychiatrist or another psychologist.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "**Use**" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "**Disclosure**" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information (PHI) for marketing purposes, and disclosures that constitute a sale of PHI require patient authorization;

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If you give me information which leads me to suspect child abuse, neglect, or death due to maltreatment, I must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, I must do so.

Adult and Domestic Abuse: If information you give me gives me reasonable cause to believe that a disabled adult is in need of protective services, I must report this to the Director of Social Services.

Health Oversight: The North Carolina Psychology Board has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.

Judicial or Administrative Proceedings: If you are involved in a court proceeding, and a request is made

for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: I may disclose your confidential information to protect you or others from a serious threat of harm by you.

Worker's Compensation: If you file a workers' compensation claim, I am required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- 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. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process. You will be notified if there is ever a breach of your unsecured PHI for any reason.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically
- Right to Restrict PHI Disclosure- You have the right to restrict certain disclosures of PHI to health plans/insurance companies if you pay out of pocket in full for the health care service

Psychologist'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 am required by law to take reasonable steps to protect unintentional disclosure through breeches of security, such as computer viruses and electronic transmission of data.
- 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 individuals with a revised notice in our next session or by US mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me in writing. We will then set up a meeting to discuss these concerns with the intent to seek a mutual resolution. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on September 27, 2013.

I will limit the uses or disclosures that I will make as follows: Your written consent is obtained, except where disclosure is required by law. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice during our next session or by US mail.

END OF NOTICE FORM

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Authorization to Release Protected Information
(APA HIPAA Compliant: 4/03)

I, _____ hereby authorize:

Name and contact details for people (such as healthcare provider, family member, etc):

_____
_____
_____

To **exchange** (two-way share)
Or (circle): release to Dr. Hamilton or receive from Dr. Hamilton

My confidential medical records and protected health information involving assessment or treatment with:

Asheville Integrated Behavioral Health, PC
William Hamilton, PhD
30 Clayton Street
Asheville, NC 28801
FAX (828) 333-4362 [secure FAX]

Without Exclusions
Or limited to or specifically excluding: _____

For the purpose of: to help with diagnosis and treatment planning
Or specify other purpose: _____

I have the right to revoke this authorization, in writing, at any time by sending such written notification to William Hamilton's office address. Any such revocation will not be effective to the extent that the releasing parties have taken action in reliance on the authorization, and that this authorization was obtained as a condition for obtaining insurance coverage, and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of this information, and may no longer be protected by the HIPAA Privacy Rule.

Today's date: _____/_____/_____

This authorization shall remain in effect until one year from today's date, or ending ____/____/____ per my specification. I also acknowledge that I have the right NOT to authorize this release of my health information, and I do so freely of my own accord.

_____ _____
Signature **Printed Name**

Date of Birth:_____/_____/_____

_____ (Witness/Guardian Signature and Printed Name)