Heather B. Scheffler, Ph.D., HSP-P
Scheffler Psychological Associates, PA
PO Box 1372, Pittsboro, NC 27312
(919) 548-5612 Office/Mobile
(919) 535-9247 Fax

Business Policies & Procedures and Informed Consent

This brochure provides information about the services I provide. **Please review it carefully and keep a copy for reference.** If you have question or concerns, please discuss them with me.

Appointments

To cover overhead costs, I charge for missed appointments or cancellations less than 24 hours in advance (unless necessary due to an emergency) following the schedule below. **Missed appointments are not reimbursed by insurance.**

First occurrence	$25 (therapy)	$50 (testing)
Second occurrence	$50 (therapy)	$100 (testing)
Third occurrence	$75 (therapy)	$150 (testing)
Subsequent occurrence	Full Price	Full Price

Inclement Weather

In times of inclement weather, please call my cell phone and leave your phone number and a message regarding your ability to travel. I will call you to confirm or to reschedule your appointment. **If you do not feel that you can travel safely, please reschedule.**

Child Care

Child care/supervision is not available during sessions. You must arrange childcare for children not involved in the therapy session. It is not appropriate for children, including the patient, to be in the room during "parent only" meetings, and other children, including siblings, should not to be in the room during clinical discussions that do not involve them.

Messages

The best way to reach me is by calling my cell phone, which should allow you to leave a voicemail message if I am not able to take your call. Due to the independent nature of my practice, I cannot promise 24-hour availability. If you have an emergency and cannot reach me, follow the instructions in the "Emergency/Crisis Services" section.

Emergency/Crisis Services

If you have an emergency at any time and cannot reach me, you may call one of the services listed below. Some insurance companies also have advice lines. **If you have a life-threatening emergency at any time, call 911 or go to your local emergency room.** Note: While all ER's provide medical stabilization, only some provide mental health services. If they feel hospitalization is needed, they will arrange transport to an available facility.

Chatham, Orange,
Alamance……..Cardinal Innovations Access Center……(800) 939-5911
Lee, Harnett, Moore,
Randolph…….. Sandhills Center Access Center…….. (800) 256-2452

Raleigh, Durham, Cumberland…….	Alliance Behavioral Health Access Center…….	(800) 510-9132
Chapel Hill……	UNC Healthlink Advice Nurse……..	(919) 966-3820
Raleigh……..	Holly Hill Hospital Assessment Counselor……..	(800) 447-1800
Greensboro……..	Moses Cone Hospital 24-hour Helpline……..	(336) 832-9700
		(800) 711-2635
Fayetteville……	Cape Fear Valley Health CareLink……..	(910) 615-5465
		(888) 728-9355

Insurance

Most routine mental health services are covered under most health insurance policies. However, some services may not be covered by your policy. Mental health coverage sometimes differs from medical coverage in terms of deductibles, co-payments, and pre-authorization. Sometimes, it is even handled by another company. Every policy is different. You should call your insurance company, ask about outpatient mental health benefits, and verify that they have me listed as "in network" or that you are aware of your out-of-network benefits if necessary.

If you have questions about your coverage, please call your insurance carrier. If you have questions about a bill from my office, call me

A co-payment is required by many insurance plans for office visits, and this co-payment is due at each visit. In addition, services not covered by your insurance policy, such as missed appointments, telephone consults, letter-writing, or school visits, are your responsibility. Making sure that your account is fully paid is your responsibility. **I cannot accept the responsibility of negotiating settlement on a disputed insurance claim.**

Fees and Billing Procedures

A current fee schedule is available upon request. **Fees, or the appropriate co-payments, are due at each visit.** Cash, checks (payable to "Scheffler Psychological Associates, P.A."), MasterCard, and Visa are accepted. Payment plans are available if needed for large deductibles, noncovered charges, etc.

It is my policy that the person who initiates services for a child is the party responsible for payment. I do not bill another person (including a non-custodial parent) unless that individual informs me *in writing* of their willingness to pay for services. This policy is for my billing purposes only and is not meant to release any party from their responsibilities as set forth in a custody agreement.

Phone Consultations/ Document Preparation

Time involved in phone consultations and document preparation (e.g., form completion, letter writing) is charged at the prorated therapy rate and is not reimbursed by insurance. A phone consultation occurs when I carry on a conversation of a therapeutic, problem-solving, or information-exchanging nature with the client, authorized family member, or another professional (teacher, doctor, attorney, etc.) for whom a consent to obtain/release information has been completed. There is no charge for short phone calls (under five [5] minutes). Document preparation refers to any time I must complete a form or write a letter, memo, summary, or report for you or another individual or agency. (A report is included in the charge for formal, standardized testing only.)

Course of Therapy/Informed Consent

At any time, clients may question and/or refuse therapeutic or diagnostic procedures or methods, or gain whatever information they wish to know about the process and course of treatment.

It is important to remember that, while therapy is often very helpful, it comes with no guarantees. Also, because the focus of therapy is often things that are difficult or problematic, discussing these things can be uncomfortable, and making changes can be difficult. Sometimes, it can even seem like things are getting worse instead of better. I encourage you to discuss these feelings with me.

Confidentiality

If I am working with your child, I am your ***child's*** therapist ***only***, and it is important that your child be able to trust me completely. Therefore, I keep confidential what your child says in the same way that I keep confidential what an adult says. I will not release specific information that the child provides without their consent (except as outlined below); however, it is appropriate to discuss with you the nature of your child's therapy, your child's progress, and your participation in treatment.

As a general rule, I uphold the confidentiality of my work with clients at all times. There are, however, certain exceptions to this rule:

1. If a therapist suspects that **child or elder abuse or neglect** has occurred, the law requires that it be reported to the authorities.
2. If a therapist believes that your child is a **clear and imminent danger to himself/herself or another person**, the therapist must notify appropriate others to prevent that occurrence.
3. If **sexual exploitation by another therapist** is reported, your therapist is required to notify appropriate person(s) or agencies.
4. In legal proceedings, patient-therapist communications are privileged with the following exceptions:
   A. If the patient's **mental status is an issue for the court** and the therapist is subpoenaed
   B. If the judge feels that communications are necessary to the **proper administration of justice** and orders their release.
5. If it becomes necessary to contact an **attorney or a collection agency**, then your name, contact information, and amount owed become available to these agents.

As of April 14, 2003, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that each patient be provided with a copy of our privacy policy. I will provide you with this statement and will answer any questions you have regarding it.

Release of Information

I require a "Release of Information" before I can release information to another party or agency. You have the right to request restrictions on how your or your child's protected health information (PHI) may be used or disclosed for treatment, payment, or health care operations. I am not required to agree to your restrictions, but if I do, I am bound by the agreement.

Revised 11/2015

I have read these policies. I understand and agree to abide by them. I understand my rights as outlined. I agree and consent for myself or my dependent to receive services as provided by Heather B. Scheffler, Ph.D.

_____ _____

Signature of parent, guardian, or authorized representative Date

_____ _____

Signature of patient/client Witness

CLIENT INFORMATION SHEET

Date: _____ **Person Completing Form:** _____

Client's Full Name: _____ **Date of Birth:** _____

Address: _____

Home Phone #: _____ **Msg OK? Y / N** **Client's Cell #:** _____ **Msg OK? Y / N**

Client's Email: _____

School/Employer: _____ **Grade/Job:** _____

Client's Primary Physician: _____ **Phone #:** _____

For minor children, please complete the following:

Who has legal custody of this child? _____

CUSTODIAL PARENT(S): (those living at address listed above)

Name: _____

Employer: _____ **Job:** _____

Work #: _____ **Msg OK? (Y / N)** **Cell #:** _____ **Msg OK? (Y / N)**

Email: _____ **Relationship:** _____

Name: _____

Employer: _____ **Job:** _____

Work #: _____ **Msg OK? (Y / N)** **Cell #:** _____ **Msg OK? (Y / N)**

Email: _____ **Relationship:** _____

List any other persons living in this home:

Name	Age	Relationship to Child	Present Health/Notes

OTHER PARENT(S): (those NOT living at address listed above)

Name: _____

Address: _____

Home Phone #: _____ **Msg OK? (Y / N)** **Cell #:** _____ **Msg OK? (Y / N)**

Email: _____ **Relationship:** _____

Name: _____

Address: _____

Home Phone #: _____ **Msg OK? (Y / N)** **Cell #:** _____ **Msg OK? (Y / N)**

Email: _____ **Relationship:** _____

List any other persons living in this home:

Name	Age	Relationship to Child	Present Health/Notes

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 INFORMATION.

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 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 the practice of Heather B. Scheffler, Ph.D., and/or within Sanford Medical Group, P.A., and/or Pinehurst Medical Clinic, Inc., such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **"*Disclosure*"** applies to activities outside of the practice of Heather B. Scheffler, Ph.D., and outside of Sanford Medical Group, P.A., and/or Pinehurst Medical Clinic, Inc., 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.

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 and/or NC Board of Medical Examiners, 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 provided neither 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.

- ***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

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 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 notify you in writing 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, Heather B. Scheffler, Ph.D., at (919) 548-5612**.**

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The Privacy Officer 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 **April 14, 2003.**

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 by US Mail.

This **state-specific** Notice form describes how psychological and medical information may be used and disclosed and how a patient can get access to this information. HIPAA requires that all patients receive this Notice Form and return the signed acknowledgment.

Heather B. Scheffler, Ph.D., HSP-P
Scheffler Psychological Associates, PA
PO Box 1372, Pittsboro, NC
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Patient Acknowledgement Form: Use & Disclosure of Protected Health Information (PHI) (HIPAA Acknowledgement Form)

Heather B. Scheffler, Ph.D., has provided me with a copy of her "**Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.**" I understand that this notice describes how Dr. Scheffler and Scheffler Psychological Associates may use and disclose protected health information (PHI) as it pertains to my mental health treatment.

By signing this form, I consent to Dr. Scheffler's business policies and use and disclosure of protected health information (PHI) about me for treatment, payment, and health care operations. I understand that I have the right to revoke this consent, in writing, except where Dr. Scheffler has already made disclosures in trust prior to my request.

_____ _____
Signature of parent, guardian, or authorized representative Date

_____ _____
Signature of patient/client Witness

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INSURANCE INFORMATION, CONSENT TO FILE INSURANCE, AND ASSIGNMENT OF BENEFITS

Patient Name: _____

Date of Birth: _____Social Security #: _____

Please complete this form and return it to our office as soon as possible. All information is needed to file claims with your insurance carrier. Please be sure to sign this form indicating your consent to pay us directly. *Names should be exactly as they appear on your insurance card.*

PRIMARY INSURANCE:

Insurance Company Name: _____

Claims Address/City/State/Zip: _____

Insurance Company Telephone Number: _____

Policy Holder (If Other Than Patient): _____

Date of Birth: _____Social Security #: _____

ID/Policy #: _____ Group Number: _____

SECONDARY INSURANCE: **[ ] Initial here if none**

Insurance Company Name: _____

Claims Address/City/State/Zip: _____

Insurance Company Telephone Number: _____

Policy Holder (If Other Than Patient): _____

Date of Birth: _____Social Security #: _____

ID/Policy #: _____ Group Number: _____

I request that payment of authorized Medicare/Medicaid/other insurance benefits be made on my behalf directly to Scheffler Psychological Associates for services provided to me or my dependent. I understand it is mandatory to notify health care providers of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply. I authorize any holder of medical or other information about me to release to my insurance companies, intermediaries, and related entities (e.g., Social Security Administration, Centers for Medicare and Medicaid Services, etc.) any information needed to determine benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that this authorization may be used by Scheffler Psychological Associates and Heather B Scheffler, PhD, until such time as I revoke this authorization in writing.

_____ _____
Signature of parent, guardian, or authorized representative Date

_____ _____
Signature of patient/client Witness