Jean McLendon, LCSW, LMFT
AAMFT Approved Supervisor
SATIR SYSTEMS
109 Conner Dr.
Building III, Suite 107
Chapel Hill, NC 27514
919-967-2520

Dear New Client,

Welcome. Please read the information that follows and answer the applicable questions. Simply indicate NA to the questions that do not apply to you. Give the completed and signed forms to me. A duplicate of my practice policies is provided for your files. If you have any questions, feel free to discus them with my Office Manager, Helen Henry, or myself.

Refreshments are available on the counter. A price sheet is taped to the wall above the counter. Bottled and filtered water and soft drinks are in the refrigerator. If you do not use disposable cups, please wash up afterwards.

Please give your check to Helen or to me, unless you have made other payment arrangements.

Regarding scheduling of appointments, usually I have my appointment book with me and can schedule appointments at one of our sessions. If there is not time to schedule then, e-mail is a preferred way for me to handle this kind of thing. Since Helen is only in the office three mornings a week, you should leave calls about appointments on my voicemail and not hers.

I look forward to meeting with you shortly.

Thank you,

Jean

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NAME(1):_____

NAME(2):_____

ADDRESS:_____

CITY:_____ST:_____ZIP:_____

BILLING
ADDRESS_____

CITY:_____ST:_____ZIP:_____

PHONE 1: DAY
(_____)_____EVE(_____)_____

PHONE 2: DAY
(_____)_____EVE(_____)_____

E-MAIL 1: _____

E-MAIL 2: _____

DATE OF BIRTH: (1)_____(2)_____

PHONE NUMBER, IF ANY, WHERE WE ARE AUTHORIZED TO LEAVE A MESSAGE IDENTIFYING THERAPIST'S NAME AND NUMBER:
HOME_____WORK_____CELL_____

A CONTACT PERSON IN CASE OF EMERGENCY:

NAME:_____RELATIONSHIP_____

DAY(_____)_____EVE (_____)_____

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I WISH TO BE BILLED AS:

PSYCHOTHERAPY
_____ Individual
_____ Group
_____ Family with patient
_____ Family without patient

OTHER/NON-INSURANCE SERVICES
_____ Couples Therapy
_____ Marital Therapy
_____ Professional Development
_____ Coaching
_____ Executive Coaching
_____ Family Consultation
_____ Consulting
_____ Supervision
_____ Professional Training

WILL YOU BE FILING INSURANCE? YES_____ NO_____

IF FILING INSURANCE, A DESIGNATED PATIENT WITH A DIAGNOSIS IS REQUIRED.

WHO IS THE DESIGNATED PATIENT?_____

ARE YOU A MEDICARE OR MEDICAID RECIPIENT, OR DO YOU ANTICIPATE BECOMING ONE DURING YOUR WORK WITH JEAN? _____YES/_____NO

JEAN IS NOT A MEDICARE NOR A MEDICAID PROVIDER, THEREFORE A SIGNED CONTRACT WILL BE NEEDED FOR YOUR SERVICES WITH HER. (SEE AND SIGN CONTRACT ON PAGES 13-16).

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REFERRAL SOURCE:

NAME _____ AGENCY _____

TELEPHONE # _____

DO YOU WANT JEAN TO TALK WITH A PREVIOUS THERAPIST(S) AND/OR THE PERSON WHO REFERRED YOU? YES _____OR NO _____

IF YES:

NAME: _____

ADDRESS:_____

PHONE NUMBER:_____

SIGNATURE FOR CONSENT:_____ DATE:_____

LENGTH OF PERMISSION-

SIGNATURE FOR CONSENT:_____DATE:_____

LENGTH OF PERMISSION_____

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# PRACTICE POLICIES

**SESSION LENGTH:**
Sessions are 45 minutes unless otherwise scheduled. Things that help you make full use of your time are scheduling a series of appointments in advance, having your check written before you arrive, and arriving early enough to enter a reflective state prior to beginning your session. Though I am responsible for monitoring and managing time boundaries, I very much appreciate your sensitivity in this matter.

**MISSED APPOINTMENTS:**
A 24-hour cancellation notice is required; otherwise you will be billed for your scheduled appointment. Cancellations for Monday appointments need to be made before noon on the prior Saturday. There are two exceptions; if the roads are dangerous due to snow or ice or if you have a contagious disease that I or others in the office might contract. (Insurance companies will not reimburse for missed appointments.) If I am working with you as a couple and you come alone without your partner, I will need to assess the risk versus value to your partnership of seeing only you. If I determine it is not in the interest of your relationship, then you will, nonetheless, be charged for the session.

**COMMUNICATIONS:**
E-mail and phone communications requiring more than 10 minutes, between you and me will be charged. There is no charge for emails concerning administrative and scheduling matters.

**E-MAIL CONFIDENTIALITY:**
There are some computer viruses that, upon infecting your computer, will take e-mails sent to you and forward them to other people on your mailing list, without your permission. This could conceivably happen to one of our confidential messages to you. To avoid this serious breach of confidence, please maintain good virus safety on your computer, including a virus checker program with a virus list that stays up-to-date. Or, if you prefer, ask us not to send any confidential communications via e-mail.

**PAYMENT:**
You are expected to make payments at each session, unless you negotiate something different. I am not a Medicare or Medicaid provider. This means that Medicare/Medicaid will NOT make any reimbursement for my services to you. For clarification see contract on pages 13-14. You must notify Jean if you become a Medicare or Medicaid recipient and sign the contract on pages 13-16 in order for Jean to provide services to you.

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**PAYMENT –CONTINUED:**
You are responsible for filing insurance claims. You are also responsible for paying for all sessions provided by me even if your insurance does not reimburse you. Your insurance or managed care company may specify a certain number of sessions and or a specific dollar amount for your mental health care. You are responsible for monitoring and keeping a record of your dollars spent and the number of sessions you have had. This information can be vital to your getting reimbursed for your care. If there is a lapse in payments and no evidence of your attempts to clear your balance, I will give you notice that I intend to turn your account over to a collection agency. All accounts placed with the collection agency are listed on your credit report.

**INVOICE POLICY:**
My customary policy is to e-mail monthly invoices to my patients and clients. Your monthly Credit Card Statement will serve as your record of payment. Please let me know if this is ok or not. If it is OK, what email address should we use?_____ If it is not ok we will make other arrangements. Please check one answer below.

Yes, OK_____ No, Not OK_____

**WHEN I AM AWAY:**
I am often away from the office due to business and other matters. During these absences, I am usually available via e-mail. If you should enter a phase of your work when you need to be assured of reaching me directly, please take the initiative to let me know. If you should have a clinical emergency and not be able to reach her immediately, call 911 or go to your nearest hospital emergency room, and ask for the psychiatrist on call.

**I look forward to being of help to you and getting to know you. It is always a privilege for me to travel with someone on their life journey.** If you have any questions or concerns about our work together, please feel free to discuss them with Helen Henry, Office Manager or with me

**Please sign and give to me.**

**Thank you,**
**Jean**

---

**Signature(s) and Date**

**Print Name_____**

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# CLIENT COPY

## PRACTICE POLICIES

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**I look forward to being of help to you and getting to know you. It is always a privilege for me to travel with someone on their life journey.** If you have any questions or concerns about our work together, please feel free to discuss them with Helen Henry, Office Manager or with me

**PLEASE TAKE THIS COPY FOR YOUR FILES**

**Thank you,**
**Jean**

---

**Signature(s) and Date**
**Print Name**_____

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Family Information: Start with all family members, and non-members, who live in the household and then include those outside the household who may also participate in the therapy.

| Family/Other Members: | Ages: | Relationship To client: | Members here today: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have any family members had problems with drugs and/or alcohol? Have they received treatment? Are they currently using?

Are you or any family members taking prescribed medications? What are they and what are they being taken for? Prescribed by _____.

Are any of those who will be coming for therapy involved in divorce proceedings? Are any minors? If so, who has sole custody or is there joint custody?

Is there involvement with DSS or other state agencies? If so, who is the contact professional at that agency?

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Are you, or is anyone else in your family, experiencing thoughts of harming yourself or someone else?

Have you or anyone in your family experienced instances of physical violence now or in the past?

Have you had problems with a natural disasters (i.e., flood, hurricane) or another traumatic event?

Do you have any special needs regarding therapy, such as a physical disability?

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CONSENT TO REQUEST OR RELEASE CONFIDENTIAL INFORMATION

I give permission to Jean McLendon

to communicate about my therapy with:

_____

Address: _____

Phone: _____

Permission shall be in effect for (length of time):_____

Signature: _____

Print Name: _____

Date: _____

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If you wish to pay by credit card, please complete this form.

The credit cards for Jean's clients are run at the beginning of the month following service.

NAME AS IT APPEARS ON THE CREDIT CARD:

_____

CREDIT CARD # _____

EXPIRATION DATE _____

TYPE OF CREDIT CARD: MC_____VISA _____DISCOVER _____AMEX_____

LAST 3 DIGITS FORM SIGNATURE STRIP IN BACK OF CARD _____

STREET# AND ZIPCODE TO WHICH THE BILL GOES:

STREET # or PO BOX #_____

ZIP CODE_____

SIGNATURE _____DATE_____

Jean McLendon, LCSW LMFT
109 Conner Dr, Bldg III, Ste 107
Chapel Hill, NC 27514
919-967-2520
jmclendon@satirsystems.com

Jean McLendon is excluded from Medicare under §§1128, 1156 or 1892 of the Medicare Act.

The beneficiary or the beneficiary's legal representative accepts full responsibility for payment of the practitioner's charges for all services furnished by the practitioner.

The beneficiary or the beneficiary's legal representative understands that Medicare limits do not apply to what the practitioner may charge for items or services furnished by the practitioner.

The beneficiary or the beneficiary's legal representative agrees not to submit a claim to Medicare or to ask the practitioner to submit a claim to Medicare.

The beneficiary or the beneficiary's representative understands that Medicare payment will not be made for items or services furnished by the practitioner.

The beneficiary or the beneficiary's representative enters into the contract with the knowledge that the beneficiary has the right to obtain Medicare-covered items and services from practitioners who have not opted-out of Medicare.

The date of the opt-out expiration is September 30, 2015. Jean McLendon intends to opt-out again at that time.

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109 Conner Dr, Bldg III, Ste 107
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jmclendon@satirsystems.com

The beneficiary or the beneficiary's legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

A new contract between the beneficiary and Jean McLendon must be entered into for each opt-out period.

---

Signed by Date

(Please print name here). _____

---

Signed, Jean McLendon Date

PLEASE SIGN AND RETURN ONE COPY OF THE CONTRACT AND SIGN AND KEEP THE OTHER FOR YOUR FILES.

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---

Signed by Date

(Please print name here). _____

---

Signed, Jean McLendon

PLEASE SIGN AND RETURN ONE COPY OF THE CONTRACT AND SIGN AND KEEP THE OTHER FOR YOUR FILES.

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# Notice of Privacy Practices

**HIPPA** (Health Information Portability & Accountability Act) Law

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**
**PLEASE SIGN OR REFUSE TO SIGN THE FOLLOWING FORM.**

My office is committed to and practices the following guidelines in order to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private; to give you this notice of my privacy practices, and to let you know if I make any changes in them.

I consider *all information* about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form", stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for payment purposes. (As needed for billing, insurance claims and collections.) For treatment, health care operations and other cases, I will ask for your authorization for use and/or disclosure of you PHI. I may not disclose your PHI without your informed and voluntary written consent or authorization. (See also, Practice Policies.)

## *Disclosure of Information*

Whenever your PHI is released or obtained, it will be the *minimum* information necessary.

There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics. These include:

- Emergencies.
- Reporting of abuse or neglect.
- Disclosures required by court order.
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

**PLEASE TAKE THIS COPY IF YOU WISH**

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## *Your Rights Regarding Privacy*

By law, you have certain rights regarding the health information that I collect and maintain about you. These rights include:

• The right to inspect and obtain a copy of your medical record.
• The right to request an amendment of any section of your medical record.
• The right to request *restriction* of disclosure of your PHI for the purposes of treatment, payment, and health care operations.
• The right to request an accounting of the disclosures that we make of your health care information.
• The right to request confidential communication.
• The right to a copy of this notice.
• The right to *refuse* to acknowledge receipt of this notice.

## *Questions and/or Exercising Your Rights*

If you have any further questions and/or concerns about this notice please contact me.

In order to exercise any of your rights described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to Jean McLendon c/o my office. You may also complain to the secretary of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-800 368-1019; or by sending an email to OCRprivacy@hhs.gov. I cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint.

I reserve the right to amend the terms of this notice.

**PLEASE TAKE THIS COPY IF YOU WISH**

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# Notice of Privacy Practices
# Receipt and Acknowledgment of Notice

**Patient/Client Name:_____**

**DOB: _____**

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact Jean McLendon at jmclendon@satirsystems.com or at 919-967-2520.

_____

**Signature of Patient/Client** **Date**

_____

**Signature or Parent, Guardian or Personal Representative** * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, parent, etc.).

**Patient/Client Refuses to Acknowledge Receipt**:

_____

**Signature of Staff Member** **Date**

## Emergency Telephone Numbers

UNC Memorial Hospital 919-966-4131
101 Manning Dr.
Chapel Hill, NC 27514

Durham Regional Hospital 919-477-4000
3643 N Roxboro St
Durham, NC 27704

Duke University Medical Center
2301 Erwin Road
Durham NC 27701 919- 684-8111

Orange County Department of Social Services
300 West Tryon Street
Hillsborough, NC 27278 919-245-2800

Durham County Department of Social Services
220 East Main Street
Durham, NC 919-560-8000
Adoption Services, Protective Services to Children, Protective Services to Women, Crisis Intervention Program, Emergency Assistance, and Protective Services for Adults

Orange County Sheriff's Office
44 E Margaret Ln.
Hillsborough, NC 27278 919-644-3050

Durham County Sheriff's Department
201 E Main St.
Durham, NC 27701 919-560-0900

Chapel Hill Town - Police Department Headquarters
University Mall Police Substation 919-932-2917

Durham Crisis Response Center
www.durhamcrisisresponse.org
206 N. Dillard St
Durham, NC 27701 Office: 919-403-9425

Family Violence Prevention Center
201 East Rosemary Street
Chapel Hill, NC 27514

24 Hour Hotline: (919)-929-7122
Toll-free: (866)–929-7122
Business Line**:** (919)-929-3872

North Carolina Alcoholics Anonymous,
Area 51 - District 32 (Durham) 919-286-9499
(local meeting schedule)

Alcoholics Anonymous, Chapel Hill NC 919-933-3877
(local meeting schedule)

National Child Abuse Hotline 1-800-354-KIDS

Narcotics Anonymous
1720 Hillsborough St
Raleigh, NC 27605 (919) 831-5100