Simply Thrive
Therapeutic Associates

1240 SE Maynard Rd, Ste 203
Cary, NC 27511
919.636.0762 (o)
513-826-9314 (f)

DEMOGRAPHIC INFORMATION

Client ____ Date ______________

Last Name First Name MI

Address ____

City ________________________ State ___________ Zip ____________________

Home Phone ____________________ May I leave you a message? ☐ Yes ☐ No

Cell Phone ____________________ May I leave you a message? ☐ Yes ☐ No

Work Phone ____________________ May I leave you a message? ☐ Yes ☐ No

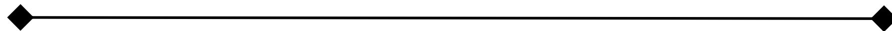
Other Phone ____________________ May I leave you a message? ☐ Yes ☐ No

Social Security # _________________________ Date of Birth ______________

Employer/School _________________________________ Full/Part time __________

Email ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Cohabitating



How did you hear about us? Check all that apply.

☐Referral from other professional ____________________________________

☐Referral from friend ____

☐Referral from insurance company ___________________________________

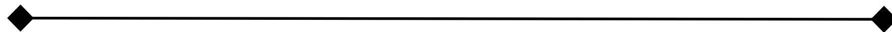
☐Internet search/Psychology Today website _____________________________

☐Other ____

Send billing statements to: ____

First Name Last Name

Address ____________________________ City_____________ State _____ Zip _____



Emergency Contact _____________________________ Phone _________________

Relationship to Client ____

Primary Care Physician ____________________________ Phone _________________

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INSURANCE INFORMATION

Insurance Company ____

Address ____

Insurance Co. Phone # ____________________ Authorization ______________________________

Subscriber # ______________________________ Group # ______________________________

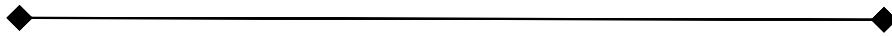
Group Name ______________________________ Employer/School ____________________

Who carries this policy? ____

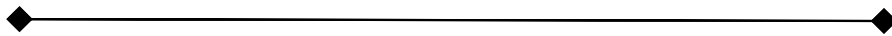
Address ______________________________ City ____________________ Zip __________

Social Security # ____________________ Sex __________ Date of Birth ____________________

Relationship to client ____



Secondary Insurance Company information *please ask for a separate form*



I, the undersigned, certify that I have insurance with ______________________________
name of insurance company

And assign directly to Simply Thrive Therapeutic Associates, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance or not.

____ __________
Client or Parent/Guardian's Signature Date

I hereby authorize Simply Thrive Therapeutic Associates, PLLC to release all information necessary to secure the payment of benefits and coordinate care. I authorize the use of this signature on all insurance submissions.

____ __________
Client or Parent/Guardian's Signature Date

____ __________
Therapist's Signature Date

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CREDIT CARD ON FILE

Payments are due at the time of service. Payment will be made through IVY Pay, cash or check, unless there is another agreement in place or unless you have insurance coverage that requires another arrangement.

This credit card on file serves as an alternate payment method in the event that the card you have on file with IVY pay is no longer valid and you have an outstanding balance, for over 30 days. This balance will include any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket expenses that accrue within the 30 day time period. Please be aware that we will not notify you of credit card being charged ahead of time, but you will receive a paid statement as a receipt by mail if your credit card is charged. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please fill in the information and sign below:

Client Name:____

Cardholder's Name:____

Credit Card #:____

Card Expiration Date:_________________________Billing Zip Code of Card:________________

Security Code (3 digits on back of card, 4 digits on the front if AmEx): ________________________

Cardholder's Signature:________________________Date:________________________________

I understand that by signing above, I am authorizing Simply Thrive Therapeutic Associates, PLLC to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, so show or late cancel fees. I understand that Simply Thrive Therapeutic Associates, PLLC will mail me a printed statement as proof of payment.

____ _______________________________
Client's Signature Date

____ _______________________________
If minor, signature of parent/guardian Date

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HISTORY

Client Name ______________________________ Date ______________

Reason for starting therapy ______________________________

Problem Areas (check all that apply):

☐ Family	☐ Work	☐ School	☐ Anger
☐ Behavior	☐ Relationships	☐ Anxiety	☐ Alcohol
☐ Drugs	☐ Eating	☐ Depression	☐ Other: ____________

What do you hope to accomplish in therapy? ______________________________

____

Physical Health Problems:

Current ______________________________

Past ______________________________

Weight______________ Height______________ Weight change in last 6 months?______________

Appetite change? ☐Yes ☐No Food or drug allergies:______________

How would you describe the nutritional value/balance of your diet?

☐Good ☐Fair ☐Poor

Tobacco Use:

☐Current ☐Past ☐Never

Packs per day______________ Other use?______________

Sleep:

How many hours per day?______________ Problems?______________

Describe any problems with sexual functioning ______________________________

____

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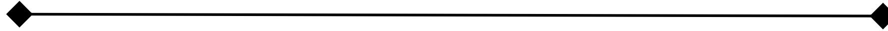


Medications:

Name Date How long? Results

Current:____

____

____

Past: ____

____

Prior Therapy or Hospitalization for Mental Health Issues:

Agency or Therapist Name When Length of Time Results

____

____

____

What was the most helpful, and what was not particularly helpful or effective?

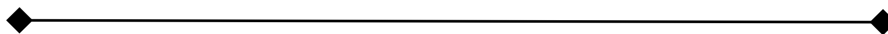
____

____

Other family members who have emotional, mental, or substance abuse problems?

____

____



Have you ever had concerns about your use of alcohol, prescription medications, or other drugs?

☐Yes ☐No

List concerns

Have you ever made a decision to cut down on or quit using alcohol or drugs?

☐Yes ☐No

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Have you experienced any of the following in connection with your use of alcohol, prescription medications, or other drugs? Check all that apply:

☐Financial Problems ☐Relationship Problems ☐Work Problems

☐Increased Tolerance ☐Physical Problems ☐Emotional Problems

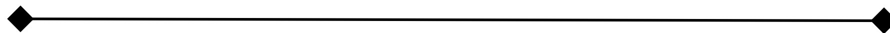
☐Blackouts ☐Withdrawal Problems ☐Cravings

☐Not Applicable

Family/Support Persons:

Who lives with you?____

Any concerns about family members or significant others?______________________________



(Optional response) Have you ever experienced:

☐Sexual Abuse ☐Physical Abuse ☐Domestic Violence

☐Emotional Abuse ☐Rape/Sexual Assault ☐Sexual Harassment

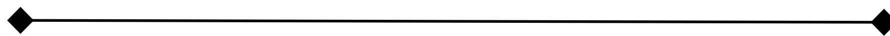
☐Other Significant Trauma ☐Prefer not to answer ☐Not Applicable

Please check the following boxes if they are difficult for you:

☐Budgeting ☐Time Management ☐Communication

☐Leisure ☐Self-Nurturing ☐Stress Management

☐Food Choices ☐Parenting ☐Not Applicable



Education:

☐	☐	☐	☐	☐
Some High School	High School Diploma	Some College	College Degree	Graduate or Post-Graduate Degree

☐Other:____

☐Prefer not to answer

Are you currently employed? ☐Yes ☐No

If yes, please specify:____

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What was your most recent previous employment?____

Are you experiencing any general financial concerns? ☐Yes ☐No

Any involvement with the legal system? ☐Yes ☐No

____

Are you currently or have you ever been probation or parole?

☐Yes ☐No ☐N/A

Have you ever been to jail?

☐Yes ☐No

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SS-77
(Ages 13+)
HOW OFTEN HAVE YOU BEEN BOTHERED BY THESE SYMPTOMS IN THE PAST FEW WEEKS?
Please use the following guidelines to answer each question,

0 Not at all bothered
1 Slightly bothered
2 More occasionally bothered
3 Moderately bothered
4 Frequently bothered
5 Constantly bothered
6 Severely bothered

1. Pain in my shoulders 0 1 2 3 4 5 6
2. Headaches 0 1 2 3 4 5 6
3. Neck and chest pain 0 1 2 3 4 5 6
4. Not knowing where I am 0 1 2 3 4 5 6
5. Troubling thoughts that repeat themselves 0 1 2 3 4 5 6

6. Feeling dizzy 0 1 2 3 4 5 6
7. Dry mouth 0 1 2 3 4 5 6
8. Feeling restless 0 1 2 3 4 5 6
9. Less interest in things I used to enjoy 0 1 2 3 4 5 6
10. Feeling nervous 0 1 2 3 4 5 6

11. Problems from alcohol or taking drugs 0 1 2 3 4 5 6
12. A need to count unimportant items 0 1 2 3 4 5 6
13. Feeling sick to my stomach 0 1 2 3 4 5 6
14. My mind going blank 0 1 2 3 4 5 6
15. Feeling guilty about alcohol or drug use 0 1 2 3 4 5 6

16. Increase in sleep walking 0 1 2 3 4 5 6
17. Try too hard to help others 0 1 2 3 4 5 6
18. Back pain 0 1 2 3 4 5 6
19. Needing to block out impulsive thoughts 0 1 2 3 4 5 6
20. Sudden fear of dying 0 1 2 3 4 5 6

21. Drinking or using drugs too often 0 1 2 3 4 5 6
22. Problems reading my own handwriting 0 1 2 3 4 5 6
23. Feeling helpless 0 1 2 3 4 5 6
24. Nightmares about something bad that happened to me 0 1 2 3 4 5 6
25. Talking in my sleep more than usual 0 1 2 3 4 5 6

26. Fear of going outside alone 0 1 2 3 4 5 6
27. Feeling like I am having a heart attack 0 1 2 3 4 5 6
28. Having to repeat certain things I do to avoid getting nervous 0 1 2 3 4 5 6
29. Feeling sensitive about my faults 0 1 2 3 4 5 6
30. Crying a lot 0 1 2 3 4 5 6

____________________________________ ____________
(client/parent/guardian signature) (date)

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31. Trouble of thinking of names of family members or close friends 0 1 2 3 4 5 6
32. Shortness of breath 0 1 2 3 4 5 6
33. Feeling anxious 0 1 2 3 4 5 6
34. Flashbacks of something bad that happened to me 0 1 2 3 4 5 6
35. Needing to use alcohol or drugs to get high 0 1 2 3 4 5 6

36. Being too unselfish for my own good 0 1 2 3 4 5 6
37. Feeling hopeless 0 1 2 3 4 5 6
38. Feeling terror 0 1 2 3 4 5 6
39. Fear of going crazy 0 1 2 3 4 5 6
40. Feeling detached from others 0 1 2 3 4 5 6

41. Problems falling or staying asleep 0 1 2 3 4 5 6
42. Stomach problems 0 1 2 3 4 5 6
43. A pounding or racing heart 0 1 2 3 4 5 6
44. Thoughts of hurting or killing myself 0 1 2 3 4 5 6
45. Thoughts about something bad that happened to me 0 1 2 3 4 5 6

46. The need to keep things extra tidy 0 1 2 3 4 5 6
47. Not remembering where or when I was born 0 1 2 3 4 5 6
48. Problems remembering bad things in my life 0 1 2 3 4 5 6
49. Feelings that things aren’t real 0 1 2 3 4 5 6
50. Needing to repeatedly wash hands 0 1 2 3 4 5 6

51. Stress at work/school or at home 0 1 2 3 4 5 6
52. Arguments with family and friends regarding my alcohol/drug use 0 1 2 3 4 5 6
53. Feeling keyed up or “edgy” 0 1 2 3 4 5 6
54. Trying too hard 0 1 2 3 4 5 6
55. Feeling worthless 0 1 2 3 4 5 6

56. Sudden fear for no good reason 0 1 2 3 4 5 6
57. Fear of bien gin a crowded place 0 1 2 3 4 5 6
58. Sadness 0 1 2 3 4 5 6
59. Muscle or body soreness 0 1 2 3 4 5 6
60. Needing to retrace my steps 0 1 2 3 4 5 6

61. Being too honest for my own good 0 1 2 3 4 5 6
62. Using too much alcohol or drugs 0 1 2 3 4 5 6
63. Feeling self-conscious 0 1 2 3 4 5 6
64. Feeling down or “blue” 0 1 2 3 4 5 6
65. Seeing things that I know aren’t real 0 1 2 3 4 5 6

______________________________________ ____________
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66. Problems concentrating 0 1 2 3 4 5 6
67. Worrying about the future 0 1 2 3 4 5 6
68. Hot or cold feelings in my body 0 1 2 3 4 5 6
69. Needing to drink or use drugs to feel better 0 1 2 3 4 5 6
70. Being too polite to other people 0 1 2 3 4 5 6

71. Feeling ashamed for using drugs or alcohol 0 1 2 3 4 5 6
72. Problems seeing things in color 0 1 2 3 4 5 6
73. Repeated checking of doors or window locks 0 1 2 3 4 5 6
74. Starting easy or feeling jumpy 0 1 2 3 4 5 6
75. Being reminded of something bad that happened to me 0 1 2 3 4 5 6

76. Having to do something many times to keep from getting nervous 0 1 2 3 4 5 6
77. Spending too much time reading or studying 0 1 2 3 4 5 6

____ ______________
(client/parent/guardian signature) (date)

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PSYCHOTHERAPIST-CLIENT SERVICE AGREEMENT

Welcome to our practice. This document contains important information about our professional services, business policies, and HIPPA (the Health Insurance Portability and Accountability Act). When you sign this document, it will also represent the agreement between you as the client and Simply Thrive Therapeutic Associates, PLLC as the clinician. ***Please initial by each area to indicate that you have read and are in agreement.***

______ **PSYCHOLOGICAL SERVICES**

We provide psychotherapy services for children, adolescents, adults, couples and families. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular issues being experienced. There are many different methods your therapist may use to address the different issues that brought you in. Psychotherapy is not like visiting the medical doctor. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things talked about both during our sessions and at home.

Psychotherapy has benefits and risks. Since therapy involves talking about the unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. The first session(s) will be an evaluation of your needs. After which your therapist will be able to offer you insight and first impressions of what your work together will include and a treatment plan to follow. If we do not think we are able to best assist you, we will give you names of other professionals who we believe would work well with your particular issues. If you do not agree with our treatment recommendations or do not think our personality styles will be a good match for you, let us know and we will do our best to suggest a different therapist who may be a better fit.

If you and your therapist decide to work together in therapy, you will collaborate on a treatment plan that incorporates effective strategies to help with whatever difficulties you are hoping to reduce in therapy. Sometimes more than one approach is helpful. Individual, couples and family therapy sessions last 45-60 minutes (depending on your insurance benefits) unless otherwise arranged. Oftentimes, sessions are set for once each week, but this varies based on what seems most appropriate for your particular situation.

If you have any questions about the procedures or are dissatisfied with anything that is happening in therapy, you and your therapist should discuss it as soon as possible. If during your work together, noncompliance with treatment recommendations becomes an issue, we will make effort to discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance may necessitate termination of therapy service. Other factors that may result in termination of therapy include, but are not limited to, violence or threats toward us, or refusal to pay for services after a reasonable time and attempts to resolve the issue.

Deciding when therapy is complete is meant to be a mutual decision, and we will discuss how to know when therapy is nearing completion. Sometimes people begin to schedule less frequently to gradually end therapy. Others feel ready to end therapy without a phasing out period of time. Please discuss with your therapist when you are feeling better and feel that your issues have been resolved. When you feel you are ready to terminate therapy, please inform your therapist at least ONE session beforehand so that you may both discuss your feelings about ending and assess the progress and growth you have made. Your signature at the end of this document indicates your agreement.

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We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings. During custody situations, we are able to testify as to what the client is exhibiting in session only and what has been expressed by the child and/or parent. Please refer to our "Professional Fees" section for more information.

______ **CANCELLATION POLICY**

Most therapy clients have a standing appointment at the same time every week or every other week. This time is reserved for you. We understand that "life happens", and while emergencies do arise from time to time, it is expected that you will keep your appointments as scheduled. **Once an appointment is scheduled, you will be expected to pay the session fee unless you give at least 24 hours advanced notice of cancellation.** When you schedule with your therapist, you reserve an hour of their time. If you do not attend, the therapist does not get paid. Additionally, that hour could have been filled by someone would needed it. Since we cannot charge insurance for this missed time, Simply Thrive Therapeutic Associates, PLLC has a no-show/ late-cancellation charge of $75.00 that will be billed directly to you, the client with your credit card on file. Your signature at the end of this document indicates your agreement.

______ **PROFESSIONAL FEES**

First session/assessment	45-55 minutes	$140
Out of Pocket/Time of Service Discount	55-60 minutes	$120
Individual Psychotherapy	55-60 minutes	$140
Individual Psychotherapy	40-45 minutes	$110
Professional time	Every 5 minutes	$10
Legal Proceedings	60 minutes	$200
Groups	60-120 minutes	$30-$60
Phone call over 10 min	Every 5 minutes	$10

In addition to weekly appointments, we charge for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of record or treatment summaries, and the time spent performing any other services you may request of us. If you become involved in legal proceedings that require our professional time, including preparation and transportation costs, *even if we are called to testify by another party*, because of the difficulty of legal involvement, we charge $200 per hour. All fees may be raised during the course of therapy. You will be notified 30 days in advance if this occurs. Your signature at the end of this document indicates your agreement to pay all associated fees.

______ **BILLING AND PAYMENTS**

You will be expected to pay for each session at the time of service, through IVY Pay, unless there is another agreement in place or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. Depending on your insurance company, you may begin paying the co-pay amount after we have verified your coverage with your insurance company. Please make checks payable to: Simply Thrive Therapeutic Associates.

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There is a re-billing fee of 1% per month for all accounts not paid after the 1st bill, unless you have made prior arrangements with your therapist or Office Manager. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, Simply Thrive Therapeutic Associates, PLLC has the option of using legal means to secure the payment (collection agency or court). In most collection situations, the information released regarding a client's treatment is his/her name, the nature of the service provided, any identifying and contact information, and the amount due. If such legal action is necessary, its cost will be included in the claim. Your signature at the end of this document indicates your agreement.

_______ **INSURANCE REIMBURSEMENT**

In order for the therapists at Simply Thrive Therapeutic Associates to set realistic treatment goals, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. The therapist and/or Office Manager will fill out forms and provide you with whatever assistance they can in helping you receive the benefits to which you are entitled; however, generally you (not your insurance company) are responsible for full payment of fees.

If there is a problem with your insurance company paying, we will try to work it out with them first. After that, we require that you pay your outstanding balance and that you take on the responsibility of collecting from your insurance company if that is allowable.

You should also be aware that your contract with your health insurance company requires that Simply Thrive Therapeutic Associates, PLLC provides them with information relevant to the services that are provided to you. Simply Thrive Therapeutic Associates, PLLC is required to provide a clinical diagnosis, and sometimes additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, Simply Thrive Therapeutic Associates, PLLC will make every effort to release only the minimum information that is necessary for the purpose requested. This information will become part of the insurance company files and will be stored in a computer. Though all insurance companies claim to keep such information confidential, Simply Thrive Therapeutic Associates, PLLC has no control over what insurance companies do with the information once it is in their hands. In some cases, they may share the information with a national medical databank. If requested, you are entitled to a copy of any reports submitted. By signing this Agreement, you agree that Simply Thrive Therapeutic Associates, PLLC can provide requested information to your insurance carrier.

Once all of the information regarding your insurance coverage is obtained, your therapist can discuss with you what can be expected to be accomplished with the benefits that are available and what will happen if the benefits run out before you feel ready to end your sessions. It is important to remember that, generally, you always have the right to pay for services yourself to avoid the problems described above.

_______ **LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a licensed mental health professional. In most situations, Simply Thrive Therapeutic Associates, PLLC can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPPA. There are other situations that require written, advanced consent. Your signature on this Agreement provides consent for these activities as follows:

- Simply Thrive Therapeutic Associates, PLLC may occasionally find it helpful to consult with other health and mental health professionals. During a consultation, the therapists at Simply Thrive Therapeutic Associates, PLLC will make every effort to avoid revealing the identity of their client. The other professionals are also legally bound to keep the information confidential. If you don't object, your therapist may not tell you about these consultations unless they feel that it is important to your work together.

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- Simply Thrive Therapeutic Associates, PLLC has contracts with electronic billing and collection services. As required by HIPPA, we have a formal business associate agreement with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise by law. If you wish, we can provide you with the name of these organizations.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where your therapist is permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is generally protected by the therapist-patient privileged law. Simply Thrive Therapeutic Associates, PLLC cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.
- If a government agency is requesting the information for health oversight activities (e.g., the North Carolina Board of Licensed Professional Counselors), Simply Thrive Therapeutic Associates, PLLC may be required to provide it to them.
- If a patient files a complaint or lawsuit against Simply Thrive Therapeutic Associates, PLLC or one of the therapists contracted with the agency, relevant information may be disclosed regarding that patient in order to provide a suitable defense.
- If a patient files a worker's compensation claim, the patient must execute a release so that Simply Thrive Therapeutic Associates, PLLC may release the information, records or reports relevant to the claim.

There are some situations in which Simply Thrive Therapeutic Associates, PLLC is legally obligated or permitted to take actions, which are believed to be necessary to attempt to protect others from harm and may result in disclosing information about a patient's treatment.

- Generally, if a therapist at Simply Thrive Therapeutic Associates, PLLC knows or have some reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, the law requires that the therapist at Simply Thrive Therapeutic Associates, PLLC file a report with the appropriate government agencies, usually Children's Services Agency. Once such a report has been filed, the therapist at Simply Thrive Therapeutic Associates, PLLC may be required to provide additional information.
- If a therapist at Simply Thrive Therapeutic Associates, PLLC has reasonable cause to believe that an elderly or vulnerable adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, the law requires that the therapist at Simply Thrive Therapeutic Associates, PLLC report such belief to the county Department of Job and Family Services or other appropriate agency.
- If a therapist at Simply Thrive Therapeutic Associates, PLLC knows or have reasonable cause to believe that a client has been the victim of domestic violence, the therapist at Simply Thrive Therapeutic Associates, PLLC must note that knowledge or belief and the basis for it in the client's records.
- If a therapist at Simply Thrive Therapeutic Associates, PLLC believes that a client presents a clear and substantial risk of imminent serious harm to him/herself or someone else and believes that disclosure of certain information may serve to protect that individual, then the therapist may disclose that information to appropriate public authorities, and/or the potential victim, and/or professional works, and or the family of the client.

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If such a situation arises, the therapist at Simply Thrive Therapeutic Associates, PLLC will, depending on the circumstances, make every effort to fully disclose it with you before taking actions and will limit disclosure to what is necessary.

______ **PROFESSIONAL RECORDS**

You should be aware that pursuant to HIPPA, Simply Thrive Therapeutic Associates, PLLC keeps Protected Health Information about you in your Clinical Record, which includes your personal data, diagnosis, and treatment plan. Simply Thrive Therapeutic Associates, PLLC keeps therapy notes brief in case someone (i.e. insurance companies, a court order, etc.) has to look at them. Simply Thrive Therapeutic Associates, PLLC uses an EHR to bill insurance called Therapy Appointment, which is HIPPA approved and secure, which minimizes risk of information being compromised. With all aspects of the internet, there is a small potential for system to be hacked. Your signature at the end of this document indicates your agreement.

______ **PATIENT RIGHTS**

HIPPA provides you with several new or expanding rights regarding your Clinical Record and disclosures of protected health information. These rights include requesting that Simply Thrive Therapeutic Associates, PLLC amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized or that are not for treatment, payment or health care operations; determining the location to which protected information disclosures are sent; having any complaints you make about Simply Thrive Therapeutic Associates, PLLC Policies and Practices to protect the privacy of your health information is provided for you . Your therapist, office manager and practice owner are happy to discuss any of these rights with you. Your signature at the end of this document indicates your agreement.

______ **MINORS AND PARENTS**

While privacy in psychotherapy is often crucial to successful progress, particularly with teens, parent involvement is also essential to success of treatment. For children 12 years of age and over, it is the policy at Simply Thrive Therapeutic Associates, PLLC, to request an agreement between the client and his/her parents which allows the sharing of general information about the progress of the client’s treatment and his/her attendance at scheduled sessions. Any other communication will require the child’s authorization, unless the therapist feels that the child is a danger to themselves or to someone else, in which case, we will notify the parents of their concern. Before giving parents any information, the child’s therapist will discuss the matter with the child, if possible, and do the best to handle any objections he/she may have. Although the therapists will attempt to prevent a parent’s access on this basis, there is no guarantee that the information can be protected from disclosure to parents. Your signature at the end of this document indicates your agreement.

______ **CONTACTING SIMPLY THRIVE THERAPEUTIC ASSOCIATES, PLLC & THERAPIST AVAILABILITY BETWEEN SESSIONS**

You may contact the office by telephone at (919) 636-0762 – your call will be returned in 2 to 4 business hours. After your initial assessment appointment, this is not the preferred method of contact in the event that you need to cancel an appointment. Please make every effort to cancel or reschedule all appointments with your therapist directly or through Therapy Appointment scheduler. Information regarding their preferred method of contact will be given to you at your first session, as well as their use of Therapy Appointment.

Due to work schedules, therapists at Simply Thrive Therapeutic Associates, PLLC are often not immediately available by phone, and do not answer phone calls while meeting with clients. If needed, you can leave your therapist a message on our office line at **(919) 636-0762**. When you leave a message, please include your telephone number even if you think we already have it, and the best times to reach you.

1240 SE Maynard Rd, Ste 203
Cary, NC 27511
919.636.0762 (o)
513-826-9314 (f)

We will make every effort to return calls in a timely manner. In the rare occurrence that a message is missed or accidentally deleted, if you do not hear back from us within one business day, please leave a second message. If your therapist is unavailable for an extended time, such as on vacation, please contact **admin@simplythrivethereapy.com** to forward your request to the on call persons.

If you are in an emergency situation and cannot wait for us to return your call, go to the nearest emergency room or call 911. Simply Thrive Therapeutic Associates, PLLC is not a crisis facility. Do not solely contact us by email or phone in an emergency, as we may not get the information quickly.

Please do not contact us through text messages or emails regarding clinical issues. These are not secure communications, and there is a possibility that we will not get the message in a timely manner, or that communication will be interpreted in an unclear manner. **Emails are only to be used for scheduling, changing or canceling appointments**. Your signature at the end of this document indicates your agreement.

______ **SOCIAL MEDIA POLICY**

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current of former clients on any social networking sites including Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns about our work together to the therapy session so we can address concerns directly. Your signature at the end of this document indicates your agreement.

My Therapist's name:____

My Therapist's number:____

My Therapist's email:____

You may revoke this Agreement in writing at any time. That revocation will be binding on me unless Simply Thrive Therapeutic Associates, PLLC has action in reliance on it; if there are obligations imposed on the agency by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Simply Thrive Therapeutic Associates

1240 SE Maynard Rd, Ste 203
Cary, NC 27511
919.636.0762 (o)
513-826-9314 (f)

Client____Date______________
First Middle Last

SIGNATURE PAGE

I understand the first 6 pages of this document is mine to keep to review if questions arise

I have read this agreement and I agree to its terms. I understand that I have the right to an explanation of the risks and benefits of each proposed treatment, of alternative treatments, and of no treatment. I understand that I can refuse treatment at any time and that I have the right to have alternative treatment approaches planned with me. We at Simply Thrive Therapeutic Associates, PLLC work hard to give you individual treatment.

Simply Thrive Therapeutic Associates, PLLC will submit claims to my insurance and I understand that the payment for services is ultimately my responsibility.

I understand copays will be processed at the time of my session.

I agree to abide by the late-cancelation/no-show policy of $75 fee.

I understand the limits of confidentiality with using insurance and online EHR providers.

I understand the therapeutic process is individualized to service each client's needs and the amount of time in session varies by the individual.

I understand if I have any concerns I can schedule a phone call or meet with the owner and we will work with you to resolve any issues.

CONSENT FOR TREATMENT

I, ________________________________, consent to treatment for myself or my minor child ________________________________ with Simply Thrive Therapeutic Associates, PLLC.

____ ______________________________
Client's Signature Date

____ ______________________________
If minor, signature of parent/guardian Date

____ ______________________________
Therapist's Signature Date