Your Center, LLC
222 Philadelphia Pike, Ste. 4
Wilmington, DE 19809
Phone: 302-298-3818 Fax: 888-801-2676

Demographic Intake Form

Patient Name_____ **D.O.B**_____ ◯ M ◯ F ◯ O (circle)

Address: _____City_____ State_____ Zip Code: _____

Email Address: _____@_____.com

Telephone number: (_____) _____-_____ **Cell Phone Number:** (_____) _____-_____

Emergency Contact: _____ **Phone Number:** (_____) _____-_____

Relationship to Patient: _____

Employer_____

Primary Care Provider: _____ **Phone Number** (_____) _____-_____

Are you on any medications? If yes, please list

_____

Do you have any health problems that we should know about circle? **Y** ◯ **or** ◯ **N**.

Please describe_____

Insurance Information Please answer all questions.

Name of Insured: _____ D.O.B (insured): _____

Name of Insurance Company: _____

Relationship to Patient: _____

ID#_____ Group#_____

Other insurance Coverage?

Ins. Name: _____

Name of insured: _____ D.O.B (insured): _____

Insurance ID#_____

By signing below, you are giving Your Center, LLC permission to bill your insurance company for services. You are also giving Your Center, LLC permission to release information necessary to bill insurance company., Your Center, LLC will only release information that is necessary for billing purposes.

Patient Name: _____ **DOB:** _____

Signed: _____ **DATE:** _____

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Problems and Concerns

What is the greatest concern for which you are seeking counseling?

Do you have thoughts of feelings of hurting yourself? If so, have you acted on them?

Have you been in counseling previously? If so where and what were the results?

What goals would you like counseling to help to achieve?

Do you have anything else important you would like to share with your therapist?

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Client Consent for Treatment

I_____, agree to enter YouR Center mental health treatment program and give consent to receive treatment as deemed appropriate by the YouR Center clinical personnel. I also understand that YouR Center personnel are obliged to provide treatment in a respectful and ethical manner. No guarantees have been made to me as to the results that may be obtained from the program. I understand that during my course of treatment certain medical or psychiatric procedures may be required by referral agencies and that I have the right to discuss and refused the use of any recommended medication.

I understand that information concerning my name and other identifying personal data from my records may be released without my specific consent in the event of a medical emergency, an in accordance with applicable Federal confidentiality regulations outlined in the release of the information form. I also understand that I may be asked to authorize by separate consent the notification of authorized officials who are responsible for me being in the treatment. I also understand that my disclosure referred two extends only to the release of required data to ensure that YouR Center maintains in its operation in accordance with Federal, State, and specific HIPAA regulations.

I have been given YouR Center client rights and responsibilities. My signature denotes my consent to treatment under one of the following conditions:

☐ **I have read all this form and the client rights form and understand the provision of both forms and give my informed consent.**

☐ **I cannot read and this form has been read to me by _____ and I understand the provision of both forms and give my informed consent to treatment.**

Client Signature:_____**Date:**____/____/____
Parents or guardian will sign for minors under age 18

Witness Signature:_____**Date:**____/____/____
(Signed and Dated: Your Center Staff only)

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION FROM / TO YOUR CENTER, LLC

Patient's Name: _____ **Date of Birth:** _____

Previous Name: _____ **Social Security #:** _____

I request and authorize _____to release healthcare information of the patient named above from / to:

Your Center, LLC
222 Philadelphia Pike Ste 4
Wilmington, DE 19809
Office: 1(302) 298-3818 Fax: 1-888-801-2676

This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, cancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. **Please circle response below**

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above, according to Section 42 CFR and HIPAA.

Patient Signature: _____ Date Signed: _____

Print Name: _____

THIS AUTHORIZATION WILL BE CONSIDERED YOUR CENTER UNLESS REVOKED IN WRITING

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PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the right to:

- Be treated with respect and dignity.
- Have fair treatment, regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
- Have his or her treatment and other patient information kept private.
- Have records released only with patient permission or when required by law.
- Easily access care in a timely fashion.
- Know about treatment choices, regardless of cost or coverage.
- Share in the development of their treatment plan.
- Have clear and understandable information about his/her condition and treatment options.
- Have information about their insurer, its practitioners, its services, and its role in the treatment process.
- Ask about the provider's work history and training.
- Give input on the Patient's Rights and Responsibility policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of his/her rights and responsibilities in the treatment process.

Patients have the following responsibilities to:

- Treat those giving them care with dignity and respect.
- Give providers honest information needed to provide care
- Ask question about his/her care to help the patient understanding the recommended care.
- Follow the agreed upon treatment plan.
- Keep scheduled appointments.
- Inform the provider when the treatment plan is not working.
- Pay any necessary fees at the time of the appointment
- Report fraud or abuse.
- Report concerns about the quality of care rendered by the provider.

I have read and understand the above stated rights and responsibilities and agree to abide by these rights and responsibilities.

Patient Signature /Guardian: _____

Print Name: _____

Date: _____

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Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth:_____

Appointment Reminders: Your Center, LLC may use your information to remind you about upcoming appointments, educational newsletters, general practice policies and/or changes, upcoming events. Typically, appointment reminders are made by text messaging, emails, and by phone calls, or a brief, non-specific message left on your voicemail.

Please let us know how you wish to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your care provided at Your Center, LLC. (Check all that apply)

May we leave a message at your home number? If yes, Detailed: Call back number only:	Yes	No
May we leave a message on your cell phone? If yes, Detailed: Call back number only:	Yes	No
May we leave a message on your work phone number? If yes, Detailed: Call back number only:	Yes	No
May we email you written communications?* If yes, email address:	Yes	No

If "NO" to all above listed, how may we contact you regarding this information?

Please list any other restrictions regarding messages or reminders about your healthcare:

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Practices" and/or consent requires your specific written authorization. If you change your mind about authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on the use and disclosure of your health information. *NOTE: As we cannot guarantee the privacy and security of individual patients' email accounts, we refrain from communicating about sensitive clinical matters via email.

By signing this document, I certify that I have read and understand the Use of this document.

Signature_____ **Date**_____

Print Name_____

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Office Policy Statement

Welcome to Your Center, LLC we look forward to working with you and we thank you for choosing our practice. It is our goal to provide you with a premium level of care and a beneficial experience, while we are involved with your care.

VOLUNTARY TREATMENT: Psychiatric consultation, evaluation, psychotherapy, and medication management are provided on a voluntary basis at the will of the treating provider with parent/guardian and patient (if of age to provide) consent. Consultation, evaluation, and prescription services are not provided under involuntary circumstances.

DISCRETION of the PROVIDER: Please be advised that all treatment (i.e. medication) is provided solely at the discretion of the treating provider based on her/his clinical judgment. The provider is under no obligation to start or continue a treatment regimen that she or he does not, in her/his clinical judgment, deem appropriate.

APPOINTMENTS: Patients are seen by appointment only. Missed appointments, "no show, no call" without prior notification (24 hours) can be assessed a No Show / Late Cancellation fee of $50. After two missed appointments or late cancellations actions may be taken to terminate care. Keeping scheduled appointments is an important part of treatment.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law or by court order. The law requires disclosure where there is a reasonable suspicion of child abuse, elder abuse or neglect; where a client presents a danger to self, to others, or to property; is gravely disabled; or is significantly impaired from drug and/or alcohol use. In these emergency situations, therapists will do whatever they can, within the limits of the law, to prevent clients from injuring self or others and to ensure that clients receive the proper care. All Your Center, LLC therapists are legally bound to keep disclosed information confidential.

- Your medical records are electronic, and may not be shared with anyone outside of the practice without your consent.
- We collaborate with other providers and in the event that we need to communicate with a provider regarding your treatment to coordinate care we will need your written consent.
- When your bills are submitted to your insurance company regarding your diagnosis and treatment dates are provided. On occasion an insurance company may request a review of your medical records, in this event you will be notified.

PAYMENT: **I agree** to pay my fee or co-pay, deductible or coinsurance at the time of services rendered. All unpaid bills, including No Show / Late Cancellation fees can be sent to collections. **Collections agencies routinely add surcharges of up to 50% of monies owed.**

_____**Initial**

PHONE CALLS: **I agree** that I will use the office numbers for routine matters including scheduling and billing concerns. After hour calls will be directed to the answering service, once a message is left the provider will be paged**. I understand** that in a true emergency, I will go directly to the nearest emergency room or call 911. I understand that routine phone calls may not be returned until the next business day. **I understand** that my provider's personal time is personal time, and if I choose to speak with him/her by telephone, I may be charged a fee for calls lasting more than 15 minutes ($25 cash per 15 minutes).

_____**Initial**

*A copy of this form will be provided at your request.
*Policy is subject to change.

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Office Policy Statement

URGENT SERVICES: We generally cannot accommodate a crisis visit during office hours. If you are experiencing a psychiatric emergency, we recommend you call 911 or go to your nearest emergency room. Other psychiatric treatment resources are listed below:

Rockford Center (302) 996-5480
MeadowWood Hospital (302) 328-3330
Psych Crisis of Christiana Care (302) 428-2118
Crisis Intervention (302) 577-2484 or (800) 652-2929

_____**Initial**

PAPERWORK and LITIGATION LIMITATION: Any paperwork carries a charge of $25 - $75. We DO NOT routinely complete short-term or long-term disability paperwork. Due to the nature of the therapeutic process, which often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorneys nor anyone else acting on your behalf, will call on your (your child's) therapist to testify in court or at any other proceeding. Nor will a disclosure of the psychotherapy records be requested. We DO NOT do any court mandated or legal paperwork for any reason, including disability, custody, etc. We can refer you elsewhere.

TREATMENT OF MINORS: Patients under the age of 18 must be accompanied by a parent or legal guardian to provide consent for treatment.

LAB WORK: From time to time, lab work may be requested. It is expected that this lab work will be completed in a timely fashion. Failure to complete requested lab work may result in changes to medication regimens where the lab work is indicated / necessary.

MEDICATIONS and PREGNANCY: Some medications are contraindicated in pregnancy. To avoid the unintended exposure of a developing fetus to medications, all women and girls of childbearing age are advised to engage in methods to avoid unplanned pregnancy such as abstinence, the use of condoms, and/or contraception.

PRESCRIPTIONS and REFILLS:

As stated above, prescriptions and refills are provided during appointments. If an appointment is rescheduled, refills will only be provided to cover until the next scheduled appointment. It may take 3 – 5 business days to complete a refill request, so please plan accordingly so that you don't run out of medication. ****Controlled substances WILL NOT be called in and require an appointment for refills.**

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Office Policy Statement

DISCHARGE: If you are discharged from the practice, you can no longer schedule appointments, obtain medication refills, or consider the treating practitioner as your provider. You will have to find a provider in another practice.

Reasons for discharge include, but are not limited to:

- Failure to keep scheduled appointments / frequent no shows
- Noncompliance, which means not following the treating providers instructions about important health issues
- Being verbally or physically abusive to provider

If you are discharged from the practice, you will be notified in writing at the address on file. One (1) 30-day prescription of medication may be provided at the discretion of the treating provider. Once you have found a new provider, sign a release form, and a copy of your records can be forwarded to the new provider.

By signing this document, I certify that I have read and understand the policies of Your Center, LLC.

Signature_____**Date**_____

Print Name_____

*A copy of this form will be provided at your request.
*Policy is subject to change.

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Effective date: 01/01/2020

NOTICE OF PRIVACY PRACTICES

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.

OUR OBLIGATIONS:

We are required by law to:
-Maintain the privacy of protected health information;
-Give you this notice of our legal duties and privacy practices regarding health information about you;
-Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our practice Privacy Officer.

For treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technician, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations: We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services: We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share health information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We may also notify your family about location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIAL SITUATIONS:

As required by Law: We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use

another company to perform billing services on our behalf. All our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect, sexual trafficking, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Date Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your Health Information.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate or a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This

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release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:
Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your Health Information to disaster relief organizations that seek your Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we can practically do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:
The following uses and disclosures of your Health Information will be made only with your written authorization:

1. Uses and disclosures for Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Health Information.

YOUR RIGHTS:
You have the following rights regarding Health Information we have about you:
Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Your Center, LLC, 222 Philadelphia Pike, Ste. 4, Wilmington, DE 19809.

We have up to 30 days to make your Health Information available to you, and we may charge you a reasonable fee for the cost of copying, mailing, or other supplies associated with your request. We may not charge you a fee if you need the information for claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: If your Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Health Information in the form or format you request, if it is readily producible in such form or format. If the Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable fee, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Health Information.

Right to Amend: If you feel that the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our office. To request an amendment, you must make your request, in writing, to: Your Center, LLC, 222 Philadelphia Pike, Ste. 4, Wilmington, DE 19809.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written

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authorization. To request and accounting of disclosures, you must make your request, in writing, to: Your Center, LLC, 222 Philadelphia Pike, Ste. 4, Wilmington, DE 19809.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to: Your Center, LLC, 222 Philadelphia Pike, Ste. 4, Wilmington, DE 19809. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Health Information to a health plan for payment or health care operation and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out of pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out of Pocket Payments: If you paid out of pocket (or in other words, if you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate only with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by phone at work. To request confidential communications, you must indicate your choice on the Protected Health Information form. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer by writing to: Your Center, LLC, 222 Philadelphia Pike, Ste. 4, Wilmington, DE 19809. All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing this document, I certify that I have read and understand the Notice of Privacy Practices of Your Center, LLC.

Signature_____ **Date**_____

Print Name_____