MEDICAL PROBLEM COUNSELING
Gary S. Grubb, LCSW, MD, MPH
NC License #C010563 105 Lochwood W. Dr., Cary NC 27518; (919) 641-3751

Consent for Treatment

I consent to an assessment process and clinical treatment with Gary S. Grubb, LCSW, MD, MPH and understand that it is his policy to provide me with appropriate and quality services at all times. If I feel that I am not receiving such services, I may request termination of services at any time during treatment. I also understand that I may withdraw from services at any time without prejudice.

Session Length: Sessions are 50 minutes in length unless otherwise scheduled. Things that 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 the beginning of your session. Please be on time for your appointment to avoid losing treatment time. My schedule generally will not allow making up time if you are late.

Cancelled or Missed Appointments: If an appointment needs to be rescheduled or canceled, please do so as soon as possible so that the time may be available to someone else. Your full fee is charged for missed appointments unless a notice of cancellation is received a full 24 hours in advance. Missed appointments or late cancellations are not reimbursable by insurance.

Payment and Insurance: You are expected to make payment at each session unless you negotiate something different. If you are filing for reimbursement, a statement will be provided to you at the end of each month that can be submitted to your insurance company. There will be a $25.00 service charge on all returned checks.

Fees: My full fee is $100 unless otherwise negotiated.

Diagnosis: Most insurance companies as standard practice require a diagnosis for the person to be treated. This diagnosis will be discussed with you and will become a permanent part of your health record.

_____ _____

Signature of Client **Date**

_____ _____

Gary S. Grubb, LCSW, MD, MPH **Date**

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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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It is also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

How I may use and disclose health information about you

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. I may use PHI to remind you of appointments and to provide information about treatment alternatives or other health-related benefits and services.

Required by Law. Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization in a limited number of other situations, including:

- To your next of kin, but limited to the fact of admission or discharge;
- To other facilities or providers when necessary to coordinate appropriate and effective care, treatment, or habitation and when failure to share the information would be detrimental to you;
- When it is deemed necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, including the target of the threat;
- When required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department);
- When required by Court Order or DSS Director;
- To an attorney who represents me;
- For research purposes if there is a justifiable need for the information.

Verbal Permission

I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission. I prefer and will likely obtain written permission as well.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing.

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend**. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication**. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of the Notice**. You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Suite 515F, HHH Building, Washington, D.C. 20201 or by calling (800) 368-1019 or go to OCRComplaint@hhs.gov. **I will not retaliate against you for filing a complaint**.

The effective date of this Notice is April 1, 2017.

I acknowledge that I have been given a copy of this Notice.

Print Name	Sign Name	Date

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Professional Disclosure Statement

Thank you for the opportunity to work with you. This handout will provide information about Dr. Grubb's background and the counseling process. If you have questions, please do not hesitate to ask.

Background

Gary S. Grubb has been a Licensed Clinical Social Worker (NC#C010563) since 2016. He holds a Masters in Social Work degree from University of North Carolina at Chapel Hill. Before becoming a social worker, Dr. Grubb earned an MD from Case Western Reserve University and a Masters of Public Health degree from the University of Minnesota. He is board-certified in Preventive Medicine and licensed in North Carolina since 1987. In his medical career he worked with the CDC, non-profit organizations, and corporations in the fields of epidemiology and clinical trials. Dr. Grubb had non-Hodgkin's lymphoma successfully treated in 2007 and has worked to address cancer patient's questions since 2009. He is the sole owner of Medical Problem Counseling (MPC).

Please Note: Although Dr. Grubb is a physician, he does not assume the role of your physician(s) in any way. He does not treat or recommend treatments for physical illness or write prescriptions or recommend medications but will refer you to a psychiatrist. Dr. Grubb uses his medical background to better understand the effects of his client's illness on your mental health, to better communicate with their physical health care providers and to help his client to better communicate with them.

Approach

Dr. Grubb's services include individual, family and group counseling. He is trained in treating depression, anxiety and PTSD. His primary training and experience is in use of Cognitve Behavioral Therapy. He has trained in Mind Body Stress Reduction Skills from The Center for Mind Body Medicine. He has additional training and experience in solution focused, interpersonal therapy and problem solving treatment.

Client-Therapist Relationship

With any of the above approaches, the quality of rapport between a client and the therapist is often the key to successful therapy. Dr. Grubb accommodates clients who are house-bound or ill by having sessions in their home but this can present some difficulties for successful therapy. Therefore, Dr. Grubb asks for certain preparations to maintain privacy and avoid interruptions with the in-home sessions.

Communication

Dr. Grubb prefers in person or telephone communication. His cell number is 919-641-3751. Phone contact can be up until 9 pm unless otherwise discussed and agreed upon.

Health and Safety

Clients or other attendees are not allowed to bring weapons, illicit drugs of any kind onto the office property or exhibit threatening behavior on office property. If there is a violation of this policy, MPC staff will direct the offender to immediately leave the premises. If this directive is not complied with, MPC staff will call 911 immediately.

Scheduling and Fee Schedule

Each individual session is 50 minutes. His full fee is $100 per hour and a sliding scale is available. Payment is expected at the end of the session. 24-hour notice is required for cancellation of a session. When an appointment is missed or cancelled without a 24-hour notice, you are responsible for payment of that session.

Dr. Grubb does not work directly with insurance carriers except Blue Cross Blue Shield (but not Local plans). He can provide billing statements upon request for clients who wish to submit for reimbursement through their insurance company. Full payment of the counseling fee is expected at each session. There will be a $25.00 service charge on all returned checks.

Questions or Concerns

If you have any questions, concerns, or statements about the counseling process at any time, please feel free to talk with Dr. Grubb about them. This is your process, and it is important that you feel comfortable. If you have a problem that you feel cannot be resolved, you may contact the North Carolina Social Work Certification and Licensure Board (NCSWCLB) at:

NCSWCLB P.O. Box 1043, Asheboro, NC 27204
Ph: (336) 625-1679 or 1 (800) 550-7009, or email: swboard@asheboro.com.

I have read the material presented in this handout as well as in the HIPAA form, asked any questions and agree to the terms of this handout.

_____ _____
Client Date

_____ _____
Gary S. Grubb, LCSW, MD, MPH Date

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PERSONAL INFORMATION

Name: _____

Address: _____

Telephone: work: _____ cell: _____ home: _____

At which phone numbers may I leave messages (circle): work cell home

Email address: _____

Date of Birth (dd/mm/yyyy): _____ Social Security#: _____

Partner/Spouse: _____ DOB: _____

Name: _____

Address: _____

Children's names and ages: _____

_____

_____

Emergency Contact: _____ Telephone#: _____

Relationship to you: _____

Employer: _____

Address: _____

Income (circle) annual/hourly: _____

Your insurance company: _____

ID number: _____

Telephone #: _____

Secondary insurance: _____

ID number: _____

Telephone #: _____

Who referred you? _____

May I send them a thank you? (circle) No Yes

Any additional information you would like to add: _____

_____

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Release of and Request for Information

I _____ (Print First and Last Name), _____ (Date of Birth) hereby authorize

Gary S. Grubb, LCSW, MD, MPH (NC Certification #C010563) to release to and hereby receive from:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____ **Fax:** _____

Cell: _____

the following information pertaining to my medical and/or mental health treatment:

diagnosis, status and progress of treatment, and other relevant information _____

_____

_____

_____ ***Initial here*** _____

for the purpose of: *provision of appropriate services* _____

_____ ***Initial here*** _____

I authorize discussion between Gary S. Grubb, LCSW, MD, MPH and the above party concerning issues pertinent to my medical/mental health care.

This authorization will expire on (*example: Date 1 year from now*) _____ , unless revoked by me in writing before that time.

_____ _____
Client's Signature **Date**

_____ _____
Counselor's Signature **Date**

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Title: _____

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_____

Telephone: _____ **Fax**: _____

Cell: _____

the following information pertaining to my medical and/or mental health treatment:

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Client's Signature **Date**

_____ _____
Counselor's Signature **Date**