



BIRD

PSYCHOLOGICAL GROUP

Client Intake Packet

Sarah Bird, PMHNP-BC-BC
13950 Ballantyne Corporate Place, Suite 155
Charlotte, NC 28277
Phone: 704-728-0937 | Fax: 980-422-0443
Email: sarahnp@birdpsych.com

Welcome to Bird Psychological Group, PLLC.

This Client Intake Packet contains important information about our services, privacy practices, communication policies, financial policies, and medication management guidelines. Please review each document carefully, as they are designed to support a safe, respectful, and transparent treatment relationship.

By signing the included forms, you acknowledge your understanding of these policies and consent to treatment. If you have any questions, please contact our office prior to your appointment.

Documents Included in This Packet

- **Informed Consent for Mental Health Treatment and Telehealth**
 - **Notice of Privacy Practices (HIPAA)**
 - **Electronic Messaging Consent**
- **Stripe Payment Authorization & Stored Card Consent**
 - **Medication Management Policies**

Client Name: _____

Client Date of Birth: _____

INFORMED CONSENT FOR MENTAL HEALTH TREATMENT AND TELEHEALTH

Nature of Treatment

I understand that I will be receiving psychiatric and mental health services from a Psychiatric Mental Health Nurse Practitioner (PMHNP-BC). Services may include, but are not limited to:

- Psychiatric evaluation and diagnosis
- Medication management
- Supportive psychotherapy
- Treatment planning
- Care coordination and referrals

I understand that treatment is voluntary and that no specific outcomes can be guaranteed.

Risks and Benefits

I understand that psychiatric treatment and prescribed medications may involve potential risks, benefits, and side effects. These will be explained to me. I may ask questions at any time and may decline or discontinue treatment.

Medications

If medications are prescribed, I understand that:

- Benefits, risks, and side effects will be discussed.
 - I am responsible for taking medications only as prescribed.
 - I must report side effects or concerns promptly.
 - Medication changes require provider consultation.
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Telehealth Consent

I consent to receive mental health services via telehealth using secure electronic communication platforms (ICANOTES).

I understand that:

- Telehealth involves the use of audio and/or video technology.
- There are potential risks, including technical failures, interruptions, or privacy limitations beyond the provider's control.
- Telehealth may not be appropriate for all clinical situations.
- I may request in-person services when clinically appropriate and available.
- Telehealth services are subject to the same confidentiality protections as in-person visits.
- I am responsible for ensuring I am in a private, safe location during telehealth sessions.

I understand that in emergency situations, I should call 911 or go to the nearest emergency department rather than using telehealth services.

Confidentiality & HIPAA

I understand that my health information is protected under HIPAA and applicable state laws. Information may be disclosed without consent only when legally required, including:

- Risk of harm to self or others
 - Suspected abuse or neglect
 - Court orders or subpoenas
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Client Responsibilities

I agree to:

- Provide accurate and complete information
 - Participate in treatment decisions
 - Follow treatment recommendations or discuss concerns
 - Notify the practice if I choose to discontinue treatment
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Right to Withdraw Consent

I understand I may withdraw this consent at any time by providing written notice. Withdrawal does not affect services already provided.

Acknowledgment

I acknowledge that I have had the opportunity to ask questions and that all questions have been answered to my satisfaction.

Consent to Treat

I voluntarily consent to psychiatric mental health treatment, including telehealth services, provided by Sarah Bird, PMHNP-BC and Bird Psychological Group, PLLC.

Client or Legal Guardian: _____

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2026

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 Legal Duty

We are required by law to:

- Maintain the privacy of your Protected Health Information (PHI)
- Provide you with this Notice of Privacy Practices
- Follow the terms of this notice currently in effect

Uses and Disclosures of Protected Health Information

We may use and disclose your PHI without your written authorization for the following purposes:

Treatment

To provide, coordinate, or manage your mental health care, including communication with other healthcare providers involved in your treatment.

Payment

To bill and collect payment from insurance companies or other payers.

Healthcare Operations

For practice operations such as quality assurance, training, licensing, and administrative activities.

Other Uses and Disclosures

We may disclose your PHI when required by law, including:

- Public health and safety reporting
- Abuse, neglect, or domestic violence reporting
- Health oversight activities
- Legal proceedings or law enforcement requests

Your Rights

You have the right to:

- Request access to or copies of your medical records
- Request amendments to your medical record
- Request restrictions on certain uses or disclosures
- Request confidential communications
- Receive an accounting of disclosures
- Receive a paper copy of this notice, even if you agreed to receive it electronically

Special Privacy Rights for Minors

Mental health privacy laws may allow minors to consent to certain types of treatment without parental involvement. When permitted by law:

- Information related to those services may not be disclosed to a parent or guardian without the minor's authorization
- Parents or guardians may have limited access to records depending on state law and the nature of services provided

We follow all applicable federal and state laws governing minor consent and confidentiality.

Parents and Legal Guardians

If the client is a minor or lacks legal capacity:

- A parent or legal guardian may sign this Notice of Privacy Practices on the client's behalf
- Access to information may be restricted as required by mental health confidentiality laws

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

- This practice (contact information below)
- The U.S. Department of Health and Human Services, Office for Civil Rights

You will not be retaliated against for filing a complaint.

Contact Information

Contact: Sarah Bird, PMHNP-BC

Phone: 704-728-0937

Email: sarahnp@birdpsych.com

Practice Address:

13950 Ballantyne Corporate Place, Suite 155

Charlotte, NC 28277

Acknowledgment of Receipt

I acknowledge that I have received a copy of this Notice of Privacy Practices.

Client or Legal Guardian: _____

Signature: _____

Date: _____

This Notice of Privacy Practices is provided in accordance with HIPAA and applicable state mental health confidentiality laws and is intended for use in psychiatric and mental health treatment settings.

Electronic Messaging Consent

Purpose

This document explains how clients and, when applicable, their legal guardians may communicate with the healthcare provider using electronic methods, including **text messaging, phone calls, voicemail, and email.**

Risks of Electronic Communication

Electronic communication involves potential risks, including unauthorized access, others viewing messages, delays, or technical failures. By choosing electronic communication, you acknowledge and accept these risks.

Appropriate Use of Electronic Messaging

Electronic messaging is **NOT appropriate for emergencies.** If you are experiencing an emergency, call **911** or go to the nearest emergency room.

Electronic messaging may be used for:

- Appointment scheduling and reminders
 - Billing or administrative questions
 - Limited clinical communication at the provider's discretion
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Opt-Out & Revocation of Consent

- I understand that I may revoke this consent at any time by notifying the practice in writing or by replying **STOP** to a text message, when applicable.
 - Revocation will not affect prior communications or my ability to receive care through other means.
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Privacy & Safeguards

- iPlum is a HIPAA-compliant texting platform
- Messages may become part of the medical record

- Clients and legal guardians are responsible for securing their devices, including passcodes and notifications
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Text Messaging Fees & Responsibility

Standard messaging rates may apply. The provider is **not responsible for unauthorized access** once messages are delivered to the client's or legal guardian's device.

Response Time & Availability

I understand that:

- Messages are reviewed during normal business hours only.
 - Response times may vary and are not guaranteed.
 - Messages sent evenings, weekends, or holidays may not be reviewed until the next business day.
 - Failure to receive a response does not indicate receipt or review of the message.
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Consent

By communicating electronically with this practice, the client or legal guardian acknowledges that:

- The **Notice of Privacy Practices** has been received and reviewed
- Risks and benefits of electronic communication are understood
- Consent is given to receive and send communications via text, phone, voicemail, and email

Client or Legal Guardian: _____

Signature: _____

Date: _____

Stripe Payment Authorization & Stored Card Consent

Bird Psychological Group PLLC
13950 Ballantyne Corporate Place, Suite 155
Charlotte, NC 28277

By providing my credit or debit card information, I authorize Bird Psychological Group PLLC to securely store my payment method using Stripe's PCI-compliant payment system. I understand and agree that my saved payment method may be used for:

- Copayments, coinsurance, and deductibles
- Self-pay services
- Outstanding balances after insurance processing
- Missed appointment or late cancellation fees according to practice policy
- Approved payment plans or recurring services

I understand that charges may be processed without my card being physically present (off-session transactions).

I understand that I may update or revoke my payment authorization at any time by providing written notice to the practice. Revocation will not affect prior charges or balances already incurred. I certify that I am the authorized cardholder and agree to this payment authorization.

Client or Legal Guardian: _____

Signature: _____

Date: _____

Medication Management Policies

Client Responsibilities

- It is the client's responsibility to update their provider with any changes in their mental or physical health history and any medication changes made with other providers outside the practice.
 - Clients must verify their insurance coverage for appointments. If insurance is inactive or canceled, the appointment may be canceled, or the client will be responsible for self-pay.
 - If insurance is not valid and the provider is not notified, self-pay fees apply. Denied claims also result in client responsibility for self-pay.
 - Clients may be required to see their primary care physician (PCP) at the provider's discretion. Health markers (e.g., blood pressure, weight, lab work, medication levels) may be required for medication refills.
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Consumer Prescription Responsibility

- Clients are responsible for obtaining, storing, and securing their prescribed medications.
 - Medications must not be shared, lost, or stolen.
 - Early refills are not provided. If a client has not been seen in 3 months, a new appointment is required before prescriptions are written.
 - Random drug screenings may be requested at the provider's discretion.
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Appointments and Cancellations

- Co-pays are required prior to all appointments; failure to pay may result in cancellation.
 - Cancel or reschedule at least 24 hours in advance to avoid a \$25 fee. Fees are charged automatically to the card on file.
 - Being late may reduce session time. More than 15 minutes late may require rescheduling.
 - Repeated no-shows or late cancellations, or failure to respond after 3 contact attempts, may result in discharge.
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Refund Policy

- No refunds or credits are provided for completed medication management services.
 - Incorrect charges will be refunded to the original payment method within 7–10 business days.
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Testing Fees

- Psychological and educational testing is an additional cost and may include formal written reports.
 - Testing fees must be paid at the time of service. Insurance often does not cover educational testing.
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Social Media and Telecommunication

- To maintain confidentiality, the provider does not accept friend or contact requests from clients on social media.
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Termination

- Termination of treatment will be discussed before ending the therapeutic relationship. Reasons may include ineffective treatment use or default on payment.
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Agreement and Signature

By signing below, I acknowledge that I have read, understood, and agree to the items contained in this document.

Client or Legal Guardian Name: _____

Signature: _____

Date: _____

Provider Signature:


Sarah Bird
PMHNP-BC

Date: _____