DIANE L. PAYNE, PH.D., P.A.
Clinical Psychology
7810 Pineville-Matthews Rd., #6 • Charlotte, North Carolina 28226 • 704.540.0625 • Facsimile 704.540.3051

DATA SHEET - MINOR (< 18)

Today's Date: ____________ Referred By: ____________

PATIENT INFORMATION

Child's Name: ____________
First Middle Last

Date of Birth: ____ / ____ / ____ Gender: ☐ Male ☐ Female Social Security #: ____________

Home Address: ____________ City: ____________ State: ______ Zip: ______

School: ____________ Grade: ______ Special Classes: ____________

PARENT'S INFORMATION

Mother's Name: ____________ Address: ____________
(if different from patient)

Mother's Employer: ____________ Address: ____________

Father's Name: ____________ Address: ____________
(if different from patient)

Father's Employer: ____________ Address: ____________

Stepparent's Name(s): ____________

Home Phone: ( ) ____________ Okay to call and leave message? ☐ Yes ☐ No

Mother's Work Phone: ( ) ____________ Okay to call and leave message? ☐ Yes ☐ No

Father's Work Phone: ( ) ____________ Okay to call and leave message? ☐ Yes ☐ No

Other Phone: ( ) ____________ Okay to call and leave message? ☐ Yes ☐ No

Email Address: ____________ Okay to leave message? ☐ Yes ☐ No

Child's Physician ____________ Phone: ( ) ____________

Address: ____________ City: ____________ State: ______ Zip: ______

INSURANCE COVERAGE

Primary Insurance Company: ____________ Phone #: ( ) ____________

Address: ____________ City: ______ State: ____ Zip: ______ Contact Person: ____________

Policy Holder: ____________ Relationship to Patient ____________

Policy Number: ____________ Employer/Group #: ____________ Social Security #: ____________

Types of Providers Covered: ____________ Prior Authorization Needed? ____ Effective Date: ____________

Other Third-party Coverage: ____________ Phone #: ( ) ____________

Address: ____________ City: ______ State: ____ Zip: ______ Contact Person: ____________

Policy Holder: ____________ Relationship to Patient ____________

Policy Number: ____________ Employer/Group #: ____________ Social Security #: ____________

Types of Providers Covered: ____________ Prior Authorization Needed? ____ Effective Date: ____________

Other provisions: ____________

I hereby authorize Diane L. Payne, Ph.D., P.A. to furnish information to insurance carriers listed above concerning the condition and treatment of the child/adolescent covered. I hereby assign to the psychologist all payments for services rendered. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**

____
Signature of Parent or Responsible Party Date

FAMILY HISTORY

Patient Name ______________________________ Date ______________
MR # ____________

I. Why do you feel your child needs treatment?

What are your goals for treatment?

What are your child's goals for treatment?

What style of discipline is utilized in the home?

What style of reward is utilized in the home?

What is your marital status? Are both parents involved with your child?

How many children are in the household? Children's ages:
Biological ______ Half ______ Step ______

During pregnancy was alcohol or any other substance used? If so, what kind and how much?

Were there any problems at birth or during pregnancy?

Is there any family history of a psychiatric disorder or any substance abuse?

Have any family members had legal complications of any kind?

Are there any custody or placement issues pending?

II. PREVIOUS TREATMENT

Therapist/Psychiatrist: Dates:

Hospitalizations:
Where? Dates:

III. MEDICATIONS

Current:

Name	Dose	Duration	Prescribed by

Past:

Name	Dose	Duration	Prescribed by

IV. TESTING

Educational:
Name: Done by:

Psychological:
Name: Done by:

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Acknowledgment of Receipt of "Notice of Policies and Practices to Protect the Privacy of Your Health Information"

The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a "Notice" regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule. The law further mandates that the patients must sign to acknowledge that they have received the "Notice".

Your signature below acknowledges you have been provided the Privacy Notice as required by the federal government's HIPAA legislation and your signature acknowledges this to be an agreement between you and your psychologist.

Date ____________________

______________________________	______________________________
Print Patient's Name	Signature
______________________________	______________________________
Print name of Parent or Legal Guardian if patient is a minor	Signature

DIANE L. PAYNE, Ph.D., P.A
Appointment Reminders

You can receive an appointment reminder to your email address or cell phone the day before your scheduled appointment.

Name: ______________________________

Email address: _________________________

Cell Phone Number: ______________________

Where would you like to receive appointment reminders? (Initial)

__________ Via text message on my cell phone (normal text message rates apply)

__________ Via email to the address listed above

__________ None of the above, missed appointment fees will still apply.

Appointment information is considered to be "Protected Health Information" under HIPPA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature: ____________________________

Date: ____________________

From the private practice of
DIANE L. PAYNE, Ph.D., P.A.
CLINICAL PYSCHOLOGY

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Fax: (704) 540-3051

OFFICE POLICIES AND PROCEDURES

Please read the following office policies and procedures carefully before signing. If you have any questions, please ask me prior to signing this agreement.

Appointments: I am available for appointments Monday through Thursday and every other Friday. The therapy "hour" is actually 50 minutes long, although longer or shorter appointments can be scheduled. You can make appointments by contacting me directly or by contacting my assistant's office at 877-693-7366 where either Meghan or Gillian can assist you. If your schedule permits, negotiating a standing appointment saves time and ensures your access to the times that work best for you.

Confidentiality: Our communication and your medical records are confidential and highly protected. No information can be released without your authorization. Exceptions to confidentiality occur when there is clear intent on your part to harm yourself or someone else; if I suspect abuse or neglect of a child, elderly or disabled adult; or if you are involved in a workman's compensation claim. In rare cases, the court or licensing board may subpoena records. These exceptions are based on existing laws. I adhere to all federal regulations of the Health Insurance Portability Act (HIPAA), which outlines patient privacy protections and patient rights.

Professional Fees: Below are the Professional fees and associated health insurance billing codes.

Insurance billing code	Therapy session	Professional Fee
90791	Initial Consultation-Individual (50-60 min)	$180.00
90832	Individual Therapy (30 min)	$90.00
90834	Individual Therapy (45 min)	$150.00
90837	Individual Therapy (60 min)	$170.00
90846	Family psychotherapy (without the patient present)	$170.00
90847	Family psychotherapy (with patient present)	$170.00

Charges not covered by insurance: I will bill on a prorated basis for other services such as report writing, letters and any other documents you request.

Letter Request	$20.00
Record Request	$15.00

Payment: Payments, co-payments and deductible amounts are due at the time of service. Checks should be made out to "Diane L. Payne, Ph.D.,P.A." There will be a $25.00 fee for all bounced checks. Accepted methods of payment are cash, check, or credit cards. It is the patient's responsibility to call their insurance company to determine the co-pay and deductible amounts with the above insurance billing codes.

Past Due Accounts: You will receive monthly statements for all outstanding balances. Accounts past due 30 days will incur a fee of 2.0% of the balance per each month the balance is unpaid. If your account is overdue by 90 days, it will be placed into pre-collections review to determine if hiring a collection agency is necessary.

Cancellations and Missed Appointments: Cancellations must be made at least 24 hours in advance. Please call and give as much notice as possible if you can, allowing me to schedule appointments for other patients who need to see me. Insurance carriers will not pay for late cancellation or missed appointment fees. Late cancellations (fewer than 24 hours before the appointment) will incur a fee of $50. Missed appointments will incur a fee of $80.00 I will work with you on a payment plan if necessary; however, payment toward the fee must be made at the next appointment time.

Insurance reimbursement: I accept and process insurance payments with Blue Cross Blue Shield of North Carolina (Blue Advantage, Blue Options, Blue Select, Blue Value, Classic Blue, and North Carolina State Health Plan), Cigna, United Healthcare, Aetna, NC Medicare, Humana, Carolina Behavioral Health, and Coventry Health (Magellan Healthcare).

Please remember that you, not your psychologist, are the policyholder. You are ultimately responsible for your bill. If your insurance company denies a claim, then you are responsible to pay the professional fee. You are responsible for informing me of any changes in your insurance or demographic information.

Self-pay and Out of Network Insurance: If you do not wish to use your insurance benefits or if you are insured by a plan which I do not particpate, full payment is expected at the time of service.

__________________________ I agree to self-pay for psychology and treatment services provided by Diane L. Payne, Ph.D., P.A.

Phone Calls and Messages: I strive to return phone calls promptly, but inevitably there can be delays. If I am unreachable for a period of several days (such as vacation, etc.); I will specify this on my confidential email.

Email and Text Messages: I prefer using email and text messages only to arrange or modify appointments. Please do not text or email me content related to your therapy sessions as email and text messages are not completely secure or confidential. If you choose to communicate with me by email or text please be aware of this. You should also know that any emails and text messages I receive from you and any responses that I send to you become a part of your medical record. If you wish to communicate something related to the content of your therapy sessions you can let me know and we can talk on the phone or in person.

Emergency Procedures: If you feel that you are having difficulties, you are encouraged to call me as soon as possible to schedule an appointment. If my office schedule is full, I will arrange a time for telephone consultation for which there will be a charge. During non-office hours, you may try calling me on my cell phone (704) 576-1918. If you cannot reach me, you may call your family physician or your psychiatrist. If it is an acute emergency that cannot wait, go to your nearest hospital or call 911.

Session Etiquette: When you come for your appointment, please come in and have a seat in the waiting room. I will come and get you at the time of your appointment. Our session will be for 50 minutes. I use the 10 minutes before sessions to process our session, write case notes, and phone calls.

Notice of Termination: You are not obliged to see me for any specific number of sessions. It is important, however, to give me one sessions' notice before ending. What I want to avoid is a situation where you cancel and then don't reschedule without explanation. A clean ending to your time together will be important for both of us.

Billing Questions: Please contact Meghan or Gillian at the billing office if you have any questions regarding insurance or statement, 877-693-7366 or help.drpayne@outlook.com

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I have read the office policies and procedures above, and have been offered a copy for my records.
I understand the policy and by my signature I agree to uphold this written policy.

____
Patient name (printed)

Patient Signature		Date
Patient/Guardian Signature	Relationship to patient	Date
Diane L. Payne, Ph.D., P.A.		Date