Cumberland Behavioral Care
2931 Breezewood Ave Suite 104
Fayetteville, NC 28303
(P) 910-491-1134 (F) 910-491-1332

Robert C Pennebaker, MSN, RN, PMHNP-BC, LCSW
Robert Andy Ayers, PA-C
Tyra Oxendine, LCMHC
Michael Carroll, LCAS, LCSW
Sue Hunt, LCSW
Denise Holmes, LCMHC
Danyelle Simmons, PMHNP-C, MSN
Ashley Clocher, MSW, LCSW
Haley Giles, LCMHC-A

Annual Patient Information Update

Name (Last, First, Middle)				
Preferred Name				
Date of Birth				
Address 1				
Address 2				
City, State, Zip				
Home Phone		Is it ok to leave a message at this number?	❑ YES	❑ NO
Mobile Phone		Is it ok to text this number? Is it ok to leave a voicemail at this number?	❑ YES ❑ YES	❑ NO ❑ NO
Work Phone		Is it ok to leave a message at this number?	❑ YES	❑ NO
Other Phone		Is it ok to leave a message at this number?	❑ YES	❑ NO
EMAIL				
Administrative Sex	❑ MALE ❑ FEMALE			
Gender Identity	❑ MALE ❑ FEMALE ❑ TRANSGENDER ❑ CHOOSE NOT TO ANSWER			
Race	❑ AMERICAN INDIAN OR ALASKA NATIVE ❑ ASIAN ❑ AFRICAN AMERICAN ❑ HISPANIC/LATINO ❑ NATIVE HAWAIIAN OR PACIFIC ISLANDER ❑ WHITE ❑ CHOOSE NOT TO ANSWER			
Language Preferred				
Marital Status	❑ MARRIED ❑ SINGLE ❑ PARTNERSHIP ❑ WIDOWED ❑ DIVORCED ❑ SEPARATED			
Employment	❑ EMPLOYED ❑ FULL-TIME STUDENT ❑ PART-TIME STUDENT ❑ UNEMPLOYED / RETIRED			
Place of Employment/School				
Address				
City, State, Zip				

Insurance Information

Primary Insurance			
Member/Subscriber ID		Group Number	
Sponsor's Information	Name	DOB	SS#

Secondary Insurance			
Member/Subscriber ID		Group Number	
Sponsor's Information	Name	DOB	SS#
Preferred Pharmacy:		**Address:**	

Please complete the portion below only if the patient is a minor

Primary Parent/Legally Responsible Person's Name	
Relationship to primary person named above	
Address (if different than child's address above)	
Contact Number (Home)	
Contact Number (Work)	
Contact Number (Mobile)	
Email	
Secondary Parent/Legally Responsible Person's Name	
Relationship to secondary person named above	
Address (if different than child's address above)	
Contact Number (Home)	
Contact Number (Work)	
Contact Number (Mobile)	
Email	

CONSENT TO TREAT AND PARTICIPATE IN TREATMENT AND ASSESSMENTS

On behalf of myself, or the consumer if a minor, I hereby consent and agree to the following conditions of participation in Clinical assessment and treatment with providers of Robert C Pennebaker, PLLC dba Cumberland Behavioral Care ("Practice"): VOLUNTARY PARTICIPATION: ***I voluntarily consent to participate in such counseling services as may be deemed necessary and appropriate by the staff of this Practice***. I understand that I will be kept informed of plans for my treatment and may withdraw my consent in writing at any time. I am aware that the practice of Professional Counseling is not an exact science and I acknowledge that no guarantees have been made to me as to the outcomes of Clinical assessments and treatments.

CONFIDENTIALITY: ***I give permission for the office staff of this Practice to provide clinical information to my insurance company or its designee, at their request, for the purpose of justifying my need for assessment/treatment and/or continued assessment treatment.*** Other verbal or written information regarding my treatment is protected by Federal law and regulations and may be released only with my specific written consent to qualified personnel for research, audit or evaluation purposes, when in the opinion of clinic staff, there is a medical emergency and release of information would be in my behalf, aid in my treatment, or protect the safety of myself and/or others or by court order.

TELEHEALTH: Informed verbal consent is obtained from the patient to communicate and provide care using virtual and other telecommunication tools. Patient has been explained risks related to unauthorized disclosure or interception of personal health information and steps they can take to help protect their information. ***I understand that care provided through video or audio communication cannot replace the need for physical examination or an in person visit for some disorders or urgent problems and patient understands the need to seek urgent care in an ER as necessary.*** Just like online shopping or email, Virtual Care has some inherent privacy and security risks of which your health information may be intercepted or unintentionally disclosed. We want to make sure you understand this before proceeding with telehealth. In order to improve privacy and confidentiality, you should also take steps to participate in this virtual care encounter in a private setting and should not use an employer's or someone else's computer/device as they may be able to access your information. If it is determined you require a physical exam, you may still need to be assessed in person. You should also understand that virtual care is not a substitute for attending the ER if urgent care is needed.

Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

FOLLOW-UP PROTOCOL: ***I agree that the office staff members of this Practice may call or write if I fail to keep an appointment to assess my need for further treatment.*** I also agree that the office staff members of this practice may contact me via letter after I have completed treatment in order to obtain information about the quality and effectiveness of the services I received at this practice.

Should you need emergency psychiatric services after the normal operating hours of this practice, you can call 9-1-1 or the nearest after-hours emergency service. Our Crisis Line can be reached by calling (910) 977-1396.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE OF SIGNATURE

Consent for Treatment and Assessment

On behalf of myself, or the consumer if a minor, I hereby consent and agree to the following conditions of participation in Clinical assessment and treatment:

1. VOLUNTARY PARTICIPATION: I voluntarily consent to participating in such counseling services as may be deemed necessary and appropriate by the staff of this Agency. I understand that I will be kept informed of plans for my treatment and may withdraw my consent in writing at any time. I am aware that the practice of Professional Counseling is not an exact science and I acknowledge that no guarantees have been made to me as to the outcomes of Clinical assessments and treatments.
2. CONFIDENTIALITY: I give permission for the office staff of this Agency to provide clinical information to my insurance company or its designee, at their request, for the purpose of justifying my need for assessment/ treatment and/ or continued assessment treatment. Other verbal or written information regarding my treatment is protected by Federal law and regulations and may be released only with my specific written consent to qualified personnel for research, audit or evaluation purposes, when in the opinion of clinic staff, there is a medical emergency and release of information would be in my behalf, aid in my treatment, or protect the safety of myself and/or others or by court order. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.
3. FOLLOW-UP PROTOCOL: I agree that the office staff members of this Agency may call or write if I fail to keep an appointment in order to assess my need for further treatment. I also agree that the office staff members of this Agency may contact me via letter after I have completed treatment in order to obtain information about the quality and effectiveness of the services I received at this Agency.

Should you need emergency psychiatric services after the normal operating hours of this Agency, you can call 9-1-1 or the nearest after-hours emergency service. Our Crisis Line can be reached by calling (910) 977-1396.

Patient Signature: _____ **Date:** _____

Authorization to Pay

Payment for services to this Agency is due when services are provided. As a courtesy to our clients and families, we will bill your insurance company in accordance with the information you provide us. It is your responsibility to keep our staff informed of any changes to your insurance coverage. You are obligated to pay any deductible, or any copay required under your insurance plan, at the time of service.

Charges are based on the type of service provided to you. If additional time or services (such as telephone sessions) are provided, a prorated fee will be charged. You remain legally responsible for all charges. Below is a list of common services and fees that clients may encounter. Your provider will discuss these fees with you at the time of the request.

Medical Records up to $35.00 for printed copies.

Letters/Reports for your insurance company or another agency up to $ 30.00

Court related costs-letters, testimony, forensic reports, etc. up to $175.00 per hour -
(Costs for testifying include travel time "door-to-door")

Services that are not covered by your insurance company up to $150.00 per hour -
(Certain types of testing, phone sessions, etc.)

Failure to give 24-hour notice of cancellation may result in a "NO SHOW" charge of $35.00. With sufficient notice, an appointment can generally be rescheduled without a fee.

Note: Per CMS rules, Medicaid recipients will not be charged "no show" fees but will be responsible for all other fees/charges that are contractually agreed to. If Medicaid does not cover the services, the consumer will be financially responsible for services received.

I authorize payment directly to this Agency. I agree to be fully responsible for all lawful debts incurred by myself or my legal dependents listed above for services received from this Agency whether covered by insurance or not. I authorize the release of any information necessary to process claims on my behalf or on the behalf of my legal dependent.

Authorization to Pay Continued

I understand that I am responsible for any co-pay, co-insurance, and/or deductible amount as per my insurance coverage on my account, and I understand that, although my claims are filed, it is not a guarantee of payment for services. Payment is expected at the time service is rendered.
Changes in my insurance coverage will be reported immediately to the office and proof of insurance will be provided by me.

Patient Signature: _____ **Date:** _____

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.**
This Agency uses an EHR, which allows providers to use information more effectively to improve the quality and efficiency of your care, but EHRs will not change the privacy protections or security safeguards that apply to your health information. EHRs and Your Health Information EHRs are electronic versions of the paper charts in your doctor's or other health care provider's office. The federal government put in place the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to ensure you have rights over your own health information, no matter what form it is in. The government also created the HIPAA Security Rule to require specific protections to safeguard your electronic health information. A few measures that have been built into our EHR system include: "Access control" tools like passwords and PIN numbers, to help limit access to your information to authorized individuals. "Encrypting" your stored information. That means your health information cannot be read or understood except by those using a system that can "decrypt" it with a "key." An "audit trail" feature, which records who accessed your information, what changes were made and when.

You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services
- Raise funds

We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

Notice of Privacy Practices Continued

•Address workers' compensation, law enforcement, and other government requests
•Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
•You can ask to see or get a copy of your medical record and other health information we have about you. Ask us how to do this.
•We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
•You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we will tell you why in writing within 60 days. •You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
•You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
•If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
•You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

•If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
•You can complain if you feel we have violated your rights by contacting us using the information provided. •You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
•We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

•Share information with your family, close friends, or others involved in your care.
•Share information in a disaster relief situation
•Include your information in a hospital directory
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:
•Marketing purposes
•Sell patient information
•Most sharing of psychotherapy notes

In the case of fundraising:
•We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures:
How do we typically use or share your health information? We typically use or share your health information in the following ways.
Treat you: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition. Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services. Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information. - We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it. - We will not use or share your information other than as described here unless you tell us we can in writing. - We can change the terms of this notice, and the changes will apply to all information we have about you. A copy of the new practices will be made available to you upon request or in our office.

Patient Signature: _____ **Date:** _____

2931 Breezewood Drive
Suite 104
Fayetteville, NC 28304
P: (910) 491-1134
F: (910) 491-1332

Authorization to Release Protected Health Information

Patient Name: _____

Patient Chart Number: _____

Date of Birth: _____ / _____ / _____

Telephone Number: _____

I hereby authorize the release of my health information from:
Robert C Pennebaker, PLLC dba Cumberland Behavioral Care • 2931 Breezewood Avenue, Ste. 104 • Fayetteville, NC 28303 • (P) 491-1134

To:

	Legal Name	Relationship	Phone/Contact Number
1.		SELF	
2.			
3.			
4.			
5.			

I understand that my medical records may contain information from other facilities that may be sent out when requested. By signing this authorization to release personal health information you are granting Cumberland Behavioral Care permission to re-disclose records we have obtained from other facilities.

The Practice is required to respond to you within (30) days of your request to inform you whether it will agree to your request or to inform you if the Practice needs more time to respond to your request.

Pursuant to the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have the right to request that CUMBERLAND BEHAVIORAL CARE (the "Practice") provide you with access to your protected health information. The Practice is not obligated to agree with your request in certain instances, including if (i) access to the information raises safety concerns, (ii) access to the information is limited by state law or court order, (iii) the PHI consists of psychotherapy notes, (iv) the PHI was compiled by the Practice or one of the Practice's Business Associates in anticipation of or for use in a legal proceeding, (v) the PHI was obtained from someone other than a covered health care provider under a promise of confidentiality and access would likely reveal the source of the information, or (iv) the PHI was created or obtained by a covered health care provider in the course of research and the individual consented to the denial of access when consenting to participate in the research. (v) CBC may not condition treatment, payment, enrollment or eligibility on signing the authorization.

I understand and authorize the release of parts of the record that relate to substance abuse, psychological/psychiatric conditions and/or communicable diseases including Acquired Immunodeficiency Syndrome (AIDS) or tests for infection with Human Immunodeficiency Virus (HIV), if present.

I understand that I may take back/cancel this authorization at any time, except to the extent that action based on the authorization has been taken. This authorization will expire automatically one year from the date signed. Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal and/or state privacy laws may not protect the re-disclosure. I fully understand this authorization and it is made voluntarily on my part.

_____ _____

Signature of Patient or Legal Representative Date

What is your Relationship to the Patient? ❑ Self ❑ Legal Representative ❑ Other _____

Do you have Medical Power of Attorney if needed for this patient or custody papers if you are not the legal parent?
❑ YES (Please provide us with a copy) ❑ NO

_____ _____

Signature of Witness Date

** RECORDS MAY NOT BE IMMEDIATELY AVAILABLE*
** THERE MAY BE A CHARGE FOR COPIES*

❑ RELEASED AT TIME OF REQUEST ❑ PICTURE ID CHECKED

For Office Use Only
Information Released

Date _____

Initials _____