The S.E.L. Group
THE SOCIAL AND EMOTIONAL LEARNING GROUP

PSYCHOTHERAPISTS TO MEET ALL OF YOUR COUNSELING NEEDS

Dear Client,

It is with pleasure that we welcome you to our psychotherapy private practice here in Greensboro, North Carolina. We have been serving the area since 2008. Our practice is proud to support individuals, families, and children on their emotional wellness journey. We offer stellar customer service and privacy to all of our clients. Let us know how we can help you and your family feel welcome to our practice.

Our goal is to empower others by providing practical skills that promote:

Self-Awareness - Recognizing one's emotions and values as well as one's strengths and limitations

Self-Management - Managing emotions and behaviors to achieve one's goals

Responsible Decision Making - Making ethical, constructive choices about personal and social behavior

Relationship Skills - Forming positive relationships, working in teams, dealing effectively with conflict

Social Awareness - Showing understanding and empathy for others

We look forward to meeting all of your counseling needs.

Sincerely,

Nannette S. Funderburk, PhD, LPCS
Owner / Psychotherapist

Keith Funderburk
Owner / Practice Administrator

3300 BATTLEGROUND AVENUE, SUITE 202, GREENSBORO, NC 27410
PHONE: 336-285-7173, FAX: 336-285-7174
EMAIL: CONTACT@THESELGROUP.COM, WEBSITE: WWW.THESELGROUP.COM

PSYCHOTHERAPISTS TO MEET ALL OF YOUR COUNSELING NEEDS

Client Registration Form

Last Name	First Name	Date of Birth	Age

Address	City	State	Zip Code

Race	Gender	Marital Status

Home Phone	Mobile Phone

Email Address	Social Security Number

Physician / Practice Name	Phone

Insurance Company	Insurance Policy Number / ID

Emergency Contact Person 1	Emergency Contact Person 2

Relationship to Client	Relationship to Client

Phone	Phone

Client Name (print) Date

Client signature

Parent / Guardian signature

3300 BATTLEGROUND AVENUE, SUITE 202, GREENSBORO, NC 27410
PHONE: 336-285-7173, FAX: 336-285-7174
EMAIL: CONTACT@THESELGROUP.COM, WEBSITE: WWW.THESELGROUP.COM

Consent For Service and Privacy Practices

This form is an agreement between you and The S.E.L. Group. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

Client Last Name: _____ Client First Name: _____ Middle Initial _____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your Client Bill of Rights are and how we can use and share your information. (Please refer to the Client Bill of Rights included in your registration packet or requested in office).

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If any situation of child abuse or elder abuse is presented.

Note: In addition, your therapist may consult with another professional concerning the most appropriate treatment.

If you do not sign this form agreeing to our privacy practices, we cannot treat you.
In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.theselgroup.com, or by calling us at, 336-285-7173.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by contacting our office in writing. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

1. Clients have the right to refuse treatment as described in the statute without threat or termination of services except as outlined in the statute.
2. Consent for treatment may be withdrawn at any time.

Consent For Service and Privacy Practices

Signature Page

Client Name (print) Date

Client signature

Parent / Guardian signature

3300 BATTLEGROUND AVENUE, SUITE 202, GREENSBORO, NC 27410
PHONE: 336-285-7173, FAX: 336-285-7174
EMAIL: CONTACT@THESELGROUP.COM, WEBSITE: WWW.THESELGROUP.COM

Client Bill of Rights

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND RETAIN FOR YOUR RECORDS.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information.

How we use and disclose your protected health information (PHI) with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If any situation of child abuse or elder abuse is presented.

Note: In addition, your therapist may consult with another professional concerning the most appropriate treatment for a client.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular method or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. (Please see the "Authorization to Release Confidential Information")

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our office to arrange how to see your records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our office. You must also tell us the reasons you want to make the changes.

To Make A Grievance / Complaint

If you wish to file a complaint against a North Carolina licensed professional counselor, you may do so by placing that complaint in writing and sending it to the NCBLPC. According to the American Counseling Association's Ethical Guidelines, you should attempt to resolve your complaint with the counselor directly. If this is not successful, you may place your concerns in writing, citing the ACA ethical codes you believe to have been broken, and submit along with a completed NCBLPC Complaint Form to the board. The board will assign your complaint a number so no names will be known to anyone but the board attorney, administrator, and ethics chair. Once the complaint has been received, notification is sent to the counselor against which the complaint was filed allowing him or her to respond to the alleged charges. If necessary, the board will investigate the complaint and issue a ruling after gathering all necessary information.

You have the right to:

- Get respectful treatment that will be helpful to you.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Ask for and get information about the therapist's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist thinks will be needed, substitute therapists (in cases of vacation and emergencies), and cancellation policies.
- Refuse to answer any question or give any information you choose not to answer or give.
- Ask that the therapist inform you of your progress.
- Access to medical care and habilitation, regardless of age or degree of mental health, developmental disabilities, substance abuse or physical disability.
- Access to their individualized written treatment plan.

Client Bill of Rights Signature Page

Client Name (print) Date

Client signature

Parent / Guardian signature

3300 BATTLEGROUND AVENUE, SUITE 202, GREENSBORO, NC 27410
PHONE: 336-285-7173, FAX: 336-285-7174
EMAIL: CONTACT@THESELGROUP.COM, WEBSITE: WWW.THESELGROUP.COM

Agreement to Pay for Professional Services

I request that The S.E.L. Group provide professional services to _____, and I agree to pay The S.E.L. Group's fee or my insurance copay of $ _____ per session for these services.

Identify your insurance company below with a check mark (√).

- ○ AETNA
- ○ BLUE CROSS / BLUE SHIELD
- ○ CIGNA
- ○ MEDICAID / NC HEALTH CHOICE
- ○ PRIVATE PAY
- ○ TRICARE (MILITARY)
- ○ UNITEDHEALTH CARE

Private Pay Fee Schedule

Initial Session Fee / Clinical Assessment	$ 100.00
Individual Therapy	$ 100.00
Couple's Therapy	$ 120.00
Child(ren) Play Therapy	$ 60.00
Family Therapy (per family)	$ 120.00
Legal Proceedings / Therapist Out of Office Requests (per appearance)	$ 300.00 per hour
Cancellation notices within a 24-hour period	$ 25.00
Disability – initial paperwork *	$ 50.00
Disability – follow-up paperwork (per request)*	$ 25.00
Letters / Special requests (per request)	$ 25.00

* Complete Disability Request Form

I agree that this financial relationship with The S.E.L. Group will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by The S.E.L. Group to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

Agreement to Pay for Professional Services
Signature Page

Client Name (print) Date

Client signature

Parent / Guardian signature

3300 BATTLEGROUND AVENUE, SUITE 202, GREENSBORO, NC 27410
PHONE: 336-285-7173, FAX: 336-285-7174
EMAIL: CONTACT@THESELGROUP.COM, WEBSITE: WWW.THESELGROUP.COM

AUTHORIZATION TO RECEIVE / DISCLOSE HEALTH INFORMATION

Client Name: _____

Date of Birth: _____

Person Authorizing Release: _____

Relationship to Client: _____

Recipient / Organization to Receive/Disclose:_____
(Name / Address / Fax / Email)

This data shall include (please check data to be received or disclosed)

- o Assessments
- o Psychiatric Evaluations
- o Psychological Evaluations
- o Diagnoses
- o Progress Notes
- o Treatment Plan / Goal
- o Discharge Summary
- o Financial Obligations
- o Substance Abuse/Treatment
- o HIV / AIDS Information
- o Other _____

Purpose of Release or Disclosure

- o At the request of individual
- o Court proceedings
- o Assessment / Evaluation
- o Determination of benefits
- o Coordination of Care

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

AUTHORIZATION TO RECEIVE / DISCLOSE HEALTH INFORMATION

Signature Page

Client Name (print) Date

Client signature

Parent / Guardian signature

3300 BATTLEGROUND AVENUE, SUITE 202, GREENSBORO, NC 27410
PHONE: 336-285-7173, FAX: 336-285-7174
EMAIL: CONTACT@THESELGROUP.COM, WEBSITE: WWW.THESELGROUP.COM

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized psychotherapy services in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to psychotherapy services in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of psychotherapy services.

Cancellation of an Appointment

In order to be respectful of the counseling needs of other patients, please be courteous and call the office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely psychotherapy services.

How to Cancel Your Appointment

To cancel appointments, please call 336-285-7173. If you do not reach the office, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations

A cancellation is considered late when a patient fails to cancel their scheduled appointment 24-hours prior to their scheduled appointment time.

No Show Policy

A "no-show" appointment is when a patient misses an appointment without notice. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

Missed, Cancellation, or No Show Service Fees

- First missed appointment: there will be no charge
- Second missed appointment: $25 fee will be billed to your account
- Third missed appointment: $25 fee will be billed to your account and you may be discharged from our practice

Repeat Cancellation, Reschedule, and/or No-Show

If a patient cancels, reschedules, and/or no shows for three consecutive appointments, the patient will not be able to schedule for three months. The exception to this will be made if the patient submits their insurance copay and S.E.L. Group no-show fee ($25.00) prior to scheduling.

Cancellation and Missed Appointment Policy

Signature Page

Client Name (print) Date

Client signature

Parent / Guardian signature

3300 BATTLEGROUND AVENUE, SUITE 202, GREENSBORO, NC 27410
PHONE: 336-285-7173, FAX: 336-285-7174
EMAIL: CONTACT@THESELGROUP.COM, WEBSITE: WWW.THESELGROUP.COM