BANYAN TREE COUNSELING

Chantal D. Hayes, M.A., LPCA, NCC, CLC

Policies and Procedures

Missed Appointments/Cancellations

Initial: _____

If you need to cancel an appointment and/or reschedule it must be done 24 hours in advance to avoid a $55.00 missed appointment fee. After 3 missed appointments Banyan Tree Counseling reserves the right to terminate continued services. I can be reached at 336-448-4451 and check my voicemail regularly. Emergency circumstances, of course, will be taken into consideration.

Inclement Weather

Initial: _____

Banyan Tree Counseling follows the Winston-Salem/Forsyth County Schools weather policy. If schools are closed, we will most likely be closed. However, please call to confirm. There will be no charges for appointments missed and rescheduled due to weather.

Insurance/Payments

Initial: _____

If your insurance company rejects your eligibility or if there is a lapse in coverage, you are fully responsible for the difference between a fee of [contracted rate]/session and the amount of the copay you have already paid. If you are using insurance, please use the Insurance Benefits Verification Form within this packet to verify your benefits before your initial session.

Fee Structure and Payments

Initial: _____

- 90791: Intake/Initial Session $115.00
- 90837/90834: Individual Counseling $95.00
- Phone calls, written reports, or correspondence more than 15 minutes: $100.00 per hour (pro-rated)

Co-pays and deductible ***payments are due at or before time of service by CASH or CHECK.*** If for some reason payment is not made or processed during session, you will receive a statement to be paid within 30 days. After 60 days, Banyan Tree Counseling will turn the balance over to Credit Collections along with a 25% administration fee. This may adversely affect your credit rating so please be conscious of prompt payments.

Legal Matters and Fee Structure

Initial: _____

Please understand I must be fully informed regarding custody situations. If there is a custody agreement, provide me with a copy of it along with any supporting documents. If I am legally requested for court testimony, please know that I am representing the child, my client, *not* the parent/s. At times, my notes may be subpoenaed. I will write summary statements when notes are requested; all parties involved may request a copy. Payments are expected the same as listed above and the same policies apply. A non-refundable $500 deposit is required 7 days prior to court date to in order for me to clear my schedule to attend, regardless if the court date is postponed. This deposit will go toward the per hour in-person court appearance amount.

- Phone consultations with attorneys: $150.00 per hour pro-rated
- Written reports and correspondence: $150.00 per hour pro-rated
- "Stand by" consultation on day of court: $150.00 per hour pro-rated
- In-person court appearance: $250.00 per hour including travel time
- Expert Letter of Recommendation for Judge: $75.00 per hour, minimum 3 hours

I have read and understand the policies and procedures of Banyan Tree Counseling. My signature below acknowledges my agreement to adhere to the expectations and I understand my obligations.

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Parent/Guardian Name (if under 18)	Parent/Guardian Signature	Date

Chantal Hayes, MA, LPCA, NCC, CLC

Professional Disclosure Statement
Office Phone/Fax: (336) 448-4451
E-mail: ChantalHayesLPC@gmail.com

Welcome to Banyan Tree Counseling. This statement, as prepared for you and required by the North Carolina Board of Professional Counselors, will hopefully answer any questions you have and help you feel more comfortable with the therapy process you are about to begin.

My Qualifications

In 2008 I earned a Master of Arts in Counseling Psychology from the University of San Francisco after receiving my Bachelor of Arts degree in English and Professional Writing from the University of North Carolina at Wilmington. I am a Licensed Professional Counselor Associate (LPCA #A9282) approved by the North Carolina Board of Licensed Professional Counselors (NCBLPC) in 2012. Since then I have attained status as a National Certified Counselor (NCC) and Certified Life Coach (CLC). As a former elementary school teacher, I have been directly working with youth for the past 12 years, the latter half which have been providing direct counseling services to children, adolescents, couples, parents, individuals and families.

LPCA Licensure

As a Licensed Professional Counselor Associate (LPCA #A9282) officiated by the NCBLPC, I am pursuing the Licensed Professional Counselor (LPC) credential. My supervisor is Kristin Reiners, M.A., LPC-S, RPT, NCC, Kinderton Counseling & Play Therapy, 3504 Vest Mill Rd. Winston Salem, NC 27103.

Counseling Background

During my master's program, I completed my internship through the University of San Francisco's Center for Child & Family Development, providing individual, group, and family counseling services to children/teens and their families. Upon graduating, I served as a therapist for adolescent and teen girls at the Greenbrier Academy for Girls therapeutic boarding school in Pence Springs, West Virginia. For several years I provided Intensive In-Home Services in Wilmington, NC, providing individual, group, and family therapy sessions for clients in their homes. I recently relocated to Winston Salem where I have held a therapy office at Reynolda Counseling (via The Children's Home), and at Wake Forest Baptist Health - Winston East Pediatrics.

My special interests include behavioral and adjustment disorders in children and teens, grief and loss, spirituality, depression/anxiety, parenting struggles, self-esteem and socialization issues, assertiveness training, effective communication and relationship concerns, divorce mediation, child sexual abuse, life transitions, women's issues including infertility, and crisis/trauma response.

There are many reasons people seek counseling; regardless of the reasons, I believe an enhanced sense of self-awareness, understanding, and acceptance is essential. It is important to understand how past experiences have shaped the way we view ourselves, as well as how we understand and relate to others. Therapy provides the opportunity for growth, self-discovery, and insight in the context of a safe, supportive environment. Each client is unique and presents with his or her own counseling needs and concerns. For this reason, there is no one approach that works best for everyone. With this principle in mind, I utilize integrative models involving cognitive-behavioral, person-centered, psychodynamic, existential, Gestalt, solution-focused, and mind-body-spirit models. At times I may also utilize Dialectical Behavioral Therapy, Motivational Interviewing techniques, and with children often utilize tailored behavioral support plans and age-appropriate play therapy. I may occasional request that clients do "homework" by way of providing further reinforcement to concepts discussed in session or simply to prompt further insight and self-exploration.

If I do not believe that I have the experience or training necessary to work with your particular situation, I will refer you to another mental health professional that may more effectively work with your concerns or difficulties.

Session Fees and Length of Service

Fees for individual 45-50 minute therapy sessions are $95 (initial session $115). Clients are expected to pay fees at the time services are rendered. The accepted methods of payment are cash or check. Clients are seen by appointment only. ***In the event you must cancel or reschedule an appointment, you must notify me via phone (336) 448-4451 AT LEAST 24-hours in advance to avoid being charged for the missed appointment***. If you are late for an appointment, I will be happy to see you for the remaining time available, but you will be expected to pay the normal fee. Due to the nature of my work, I may not always be readily available by phone should you need to speak with me outside of your session time. However, I do check my messages periodically and generally try to return phone calls within the same business day.

Use of Diagnosis

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require a diagnosis of a mental-health condition before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records. I utilize the Diagnostic and Statistical Manual of the American Psychiatric Association, Fifth Edition (DSM-5) to make clinical diagnoses.

Confidentiality

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Questions or Complaints

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819 Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007 Fax: 336-217-9450
E-mail: Complaints@ncblpc.org

Acceptance of Terms

We agree to these terms and will abide by these guidelines.

Client Name (Print)	Client Signature	Date
Parent/Guardian Name (if under 18)	Parent/Guardian Signature	Date
Chantal Hayes, MA, LPCA #A9282 Counselor Name	Counselor Signature	Date

Consent For Treatment

I hereby give my consent to my clinician, Chantal D. Hayes (MA, LPCA, NCC) to provide evaluation, treatment and/or other services that we may mutually determine to be appropriate. I understand that services will be rendered in a professional manner, consistent with accepted ethical standards.

I understand that I will likely gain the most benefit from counseling if I am committed to the process and attend regularly. I also understand that it is not uncommon, over the course of therapy, to temporarily experience increased distress. This is an indicator that important work is underway and significant changes are beginning. I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist.

I acknowledge that I have received and have read the professional disclosure statement and the HIPAA information sheet. I understand that I may ask questions at any time about any of the information given to me, and about treatment options. In addition, I am aware of the constraints involved with confidentiality.

I understand that the fee for the initial assessment it $115.00 and $95.00 for subsequent sessions. I have read the fee schedule and understand that I must cancel an appointment at least 24 hours in advance otherwise I will be assessed a $55.00 fee. Payment is due and payable to the therapist at the beginning of each session. Fees may be paid via check or check. I understand if payments are not made the therapist has the right to stop treatment. I understand that phone calls will be returned to me within a 24-hour period. If I am in an emergency situation I will seek help immediately from an emergency room.

_____ _____

Patient signature Date

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS:

I give Chantal D. Hayes consent to treat minor child _____

_____ _____

Signature of Parent or Legal Guardian Date

Consent of Non-secure Forms of Electronic Communication

I am available via phone, voicemail, and email. Feel free to use these means to communicate regarding scheduling, changing of appointments, tardiness, or non-clinical emergencies. However, please be advised that *confidentiality cannot be guaranteed using these media*. Electronic communication such as Gmail and Skype, are not considered "secure." While I do not share any accounts/passwords and take strong efforts to protect your confidentiality, there is some risk that any protected health information contained in email/phone/voicemail/skype may be disclosed to or intercepted by unauthorized third parties.

** Important communications, including anything clinical in nature, are to be done in person.*

Notice Regarding Social Media & Online Presence:

I maintain a professional and personal online presence via various social media/networking platforms. My policy is to deny any personal connection requests by clients, although you are welcome to follow my professional pages or blogs. However, please know that any social media private messages will be deleted or ignored, as communication should be made in-person, or via email or phone. While I will never address you online, it does not protect you from others inferring you are in treatment.

By signing below, you are acknowledging that you realize email and phone communication does not provide a completely secure means of communication.

Your treatment will not depend on you giving consent. You also have the right to terminate this agreement at any time.

I give permission for my therapist to contact me using non-secure methods regarding reminders, scheduling, or other relevant matters, and I understand the risks involved:

Email/Text Communication: ☐ **YES** ☐ **NO**

Phone/Voicemail Communication: ☐ **YES** ☐ **NO**

Online Video Communication: ☐ **YES** ☐ **NO**
(such as Skype, Google Video, etc)

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date
_____	_____	_____
Printed Name of Legal Guardian *(if under 18)*	Signature of Legal Guardian	Date

HIPAA Notice of Privacy Practices

Chantal D. Hayes, MA, LPCA
1348 Westgate Center Dr. Ste. 203 Winston Salem, NC 27103
(336) 448-4451 chantalhayesLPC@gmail.com

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 Notice of Privacy Practices describes how we may use and disclose your *protected health information* (PHI) to carry out *treatment, payment or health care operations* (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your counselor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the counselor's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your counselor's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your counselor. We may also call you by name in the waiting room when your counselor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your counselor or the counselor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information. ***You have the right to inspect and copy your protected health information (fees may apply)*** – Under federal law, however, you may ***not*** inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior six years prior to the date of this request.
You have the right to obtain a paper copy of this notice from us. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to me or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. **I will not retaliate against you for filing a complaint.** I am required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. I am also required to abide by the terms of the notice currently in effect.

Please sign below to acknowledge receipt of this form.

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Banyan Tree Counseling/Chantal D. Hayes's Notice of Privacy Practices. By signing below, I am giving acknowledgment that I have received or have had the opportunity to receive the Notice of her Privacy Practices.

_____ _____

Patient/Legal Guardian Signature **Date**

CLIENT'S BILL OF RIGHTS
Banyan Tree Counseling

- Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided.
- Each client has the right to accept or refuse all or part of his/her care and /or have the expected consequences explained.
- Each client has the right to expect that all treatment records or information will be kept confidential in compliance with agency policy except as authorized and as required by law. No information/records will be released without written permission of client or other appropriate designee, except to the physician, insurance company or hospital/facility client transferred to. The client will have access to all their health care records.
- Each client has the right to exercise personal privacy by withholding consent or family's or significant other's participation and to be informed of the possible consequences of that action.
- Each client has the right to be informed of the nature and purpose of any services rendered and the title of personnel providing that service.
- Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on the service provided and be aware of the process of voicing those grievances.
- It is the right of each client to receive individualized treatment which includes:
    - Adequate and humane services regardless of the source of financial support.
    - Services provided in the least restrictive environment possible.
    - An individualized treatment plan, which is reviewed periodically and as needed.
    - To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate.
- If at any time during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency - they have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.
- The client has the right to request a referral for services, which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.
- The client will be informed of his/her rights in a language they can understand.
- Each client has the right to refuse to participate in any research projects without compromising their access to the organizations resources.
- Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.
- Each client has the right to make decisions regarding the withholding or resuscitative measures with these decisions respected per agency policy.

The above Bills of Rights have been reviewed with me and any questions I may have had were explained to my understanding. A copy of the Client's Bill of Rights was provided to me.

_____ _____

Patient/Legal Guardian Signature Date

BANYAN TREE
COUNSELING

Banyan Tree Counseling Cancellation Policy

Due to the demand for appointments it is very important that you let your therapist know 24 hours in advance if you will not be able to keep your appointment. As is outlined in our office policy form, any missed appointment that was not cancelled within 24 hours will be billed as a $55.00 missed appointment fee. Of course, sudden illness or unforeseen emergencies will be taken into consideration.

Consent for Charging

I have read and understand the cancellation policy. I give Banyan Tree Counseling permission to charge my credit card $55.00 for any missed appointments that have not been cancelled 24 hours in advance. I understand this is the only reason my credit card would be charged and will not be shared or used for any other purposes.

TYPE OF CARD (Visa/MasterCard/Discover/AmEx): _____

CARD NUMBER: _____

CSV CODE: _____

** Three-digit security code printed on the back signature panel of your card (final three numbers)*

EXPIRATION DATE: _____-_____-_____

SIGNATURE_____

BANYAN TREE
COUNSELING

Chantal D. Hayes, M.A., LPCA, NCC, CLC
Licensed Professional Counselor Assoc. #A9282
1348 Westgate Center Dr. Suite 203
Winston Salem, NC 27103
Phone/Fax: (336) 448-4451
chantalhayesLPC@gmail.com

MENTAL HEALTH/BEHAVIORAL HEALTH INSURANCE BENEFITS VERIFICATION FORM

Patient's Name: _____

Patient's Date of Birth: _____-____-_____

Policy Holder's Name (if different from patient):_____

Policy Holder's Date of Birth: _____-_____-_____ Policy Holder's Soc. Sec. #: _____-_____-_____

Primary Insurance/Behavioral Health Insurance Plan: (*Note: This may be different from your medical health insurance plan)*

_____

Member ID #: _____ Group #: _____

Dependent's ID #: *(if child is the patient, there should be a number listed after his/her name):* _____

Effective Date of Policy: _____-____-_____ Expiration Date of Policy: _____-____-_____

Questions for Your Insurance Provider:

1) "Do I have mental/behavioral health coverage?" □ YES □ NO
   *(If **YES**, continue. If **NO**, there is no need to proceed; other payment arrangements must be made. Please contact therapist to discuss payment options.)*
2) "Is my preferred therapist Chantal Hayes, MA, LPCA in network?" □ YES □ NO
   *(If **YES**, go to In-Network Coverage, If **NO** go to question 3)*
3) "Do I have Out-of-Network benefits?" □ YES □ NO
   *(If **YES**, go to Out-of-Network benefits. If **NO**, there is no need to proceed; other payment arrangements must be made. Please contact the therapist with whom you want to work to discuss payments options.)*

In-Network Coverage

4) "What is my co-pay amount?" $_____
5) "Do I have a deductible?" □ YES □ NO
6) If **YES**, "What is my deductible?" $_____

*(Now proceed to **Services Covered**)*

Out-of-Network Benefits

7) "How much will I be reimbursed if I see an Out-of-Network therapist?" $_____
8) "Do I have an Out-of-Network deductible?" □ YES □ NO
   If **YES**, "What is my out-of-network deductible?" $_____

Services Covered

9) "Can you please verify that the following services are covered under my policy?"
   •Individual Therapy □ YES □ NO •Family Therapy □ YES □ NO •Group Therapy □ YES □ NO

Services Authorized

10) "Do I need an authorization to receive any of these services?" □ YES □ NO
    If **YES**, "What is my authorization number?" _____
11) "How many sessions are authorized?" _____

BANYAN TREE
COUNSELING

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

Your PCP is the medical representative responsible for coordination of your total care. Therefore it is appropriate for him or her to be aware of the behavioral/mental health therapy taking place under my care. With your permission, I would like to communicate basic treatment information to your PCP after your initial evaluation.

Please initial the appropriate statement:

- Please DO NOT contact my PCP after my initial session: _____
- Please DO contact my PCP after my initial session: _____

Primary Care Physician: _____

Address: _____

(city)_____ (state) _____ (zip) _____

Phone: _____ Fax: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if under 18)

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