Welcome

Welcome! We are glad we will be seeing you soon. Please take some time to review and sign all of these documents prior to your first appointment. We ask that you complete these at least two weeks prior to your meeting with the therapist. Doing so will allow us to review the information and use your time efficiently during your time together.

Please note that this packet will require you to move through the following steps: 1) download to your computer, 2) open the document using any .pdf reading software (Adobe Acrobat, Preview, etc), 3) type to fill in the blanks and sign, 4) save, and 5) upload back to the portal. Once you upload, you will then be able to e-sign documents.

Lastly, in order to upload your insurance card and previous evaluations, please download the next two blank documents and replace them with your documents. Please let us know if you have any questions.

Thank you for completing these! We appreciate it and look forward to working with you.

1. Name and email: _____

Dr. Glori Gray & Psychological Associates
360 North Caswell Road | Charlotte, NC 28204
W: https://drglorigray.com | **P:** (704) 765-2549
E: help@drglorigray.com | **F:** (704) 765-4749

Client's Name _____ **Client's Date of Birth**_____

(Please read carefully.)

LCMHCA Professional Disclosure Statement

Latrelle Rogers, MA, BCBA

Qualifications and Experience

I earned my Bachelor's Degree from Salisbury State University (Psychology), a Master's Degree in Behavioral Sciences (Applied Behavioral Analysis) from the University of Houston-Clear Lake, and a second Master's in Clinical Mental Health Counseling from University of Southwest. My work is focused on serving children/adolescents and their families by providing clinic, school, and community-based therapy.

Restricted Licensure

I am currently pursuing provisional licensure as a Professional Counselor Associate in North Carolina. I am currently under the supervision of Glori Gray, PsyD. Dr. Gray can be contacted via email at glori@drglorigray.com or by phone at 704-765-2459.

Counseling Background

During my graduate career, I have gained clinical counseling experience working with concerns related to anxiety, adjustments/life transitions, relational problems, eating disorders, school/work difficulties, grief and loss, depression, self-esteem issues, parenting difficulties and family conflict.

As a clinician, I embrace a strengths-based perspective, and I borrow from many different theory bases for psychotherapy in aiming to understand and meet the individual needs of each person and of each family. These theories include cognitive-behavioral, solution-focused, reality-based, mindfulness-based and family systems theories. Techniques that I utilize may include play therapy, dialogue, psychoeducation, relaxation, reframing of negative thoughts, positive decision-making, role-play, mindfulness, or writing/art exercises. We will work together to establish realistic and attainable goals for you to achieve. These goals are flexible, and we may modify them throughout the therapy process as your needs change. Active participation in and out of session is essential to your success. I will often assign tasks between appointments to help strengthen the skills you acquire during therapy and empower you to resolve issues after the therapeutic relationship has ended.

Record Keeping and Confidentiality:

The information shared with me is considered legally privileged and confidential; typically, information will not be shared with anyone unless the legal guardian has given written authorization for me to do so. There are some exceptions to this confidentiality, when information may be shared without the legal guardian's authorization. For example, I may disclose information without written authorization in the following situations:

• If I am ordered to do so by a court of law;

• If I receive first-hand information about harm done to a child, an elder, a mentally ill adult, or a mentally disabled adult;

• In certain emergency situations;

• When collaborating with another health care provider about the child's immediate needs, including providers at the hospital from which the client was referred.

Please note that both of a child's legal parents, whether custodial or not, have the right to access psychological information maintained about a minor child. A comprehensive Notice of Privacy Practices is available. This notice explains the Health Insurance Portability and Accountability Act (HIPAA), a federal law providing privacy protections with regard to the use and disclosure of Protected Health Information (PHI).

***Please note: I do not conduct custody assessments, parenting competency assessments for family court proceedings, or consultation/assessment around custodial visitation issues. Because of this, I do not agree to provide expert witness services in family court cases involving questions of custody, parental visitation, or other divorce-related matters.

(See further information about our requirements and your rights in NC, if you are divorced or separated, below.)

Electronic Communications and Social Media:

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. Occasionally, email may be the best way for me to send you information (e.g., a handout, links to websites). I will only do this with your permission, and your understanding that email is not secure. I am required by law to keep a written record of all correspondence. Please do not use email to communicate sensitive information to me. If you do, you assume the risk of disclosure. If you or a child need to discuss a clinical matter with me, please feel free to call the office so we can discuss it on the phone or wait so we can discuss it during our next session. To protect your privacy, I do not communicate with, or contact, any of my clients through social media. These types of casual social contacts can create significant security risks for clients.

Use of Diagnosis:

Some health insurance companies will reimburse clients for counseling services, and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an "illness" 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.

Complaints:

I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf). Please first discuss any concerns with me; I am happy to work through them with you. If that is not satisfactory, please contact my supervisor. If we are collectively unable to settle the matter, and you feel I am in violation of any of these codes of ethics, you may file a complaint against me with the organization below.

North Carolina Board of Licensed Clinical Mental Health Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: complaints@ncblcmhc.org

* If you have to cancel for any reason, please recognize that cancellations within 24 hours will result in a charge for the full time reserved with me. This is with the understanding that I am not able to reserve that time with others who are interested in meeting during that same period. I will extend a 1-time courtesy for therapy appointments in which the child or parent is sick or when there is a true emergency. You are asked to email me in addition to calling the main office, so that I can ensure that you are not charged for the time.

Please *initial that you have understood the statements above. By signing this form, you* are *agreeing to the terms and conditions stated herein.*

Guardian/Client's Signature:_____

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 Client's Name: _____

FEES, PAYMENT & INSURANCE

Session Fees, Insurance, Length Of Services, and Cancellation Policies

- Individual counseling sessions with Latrelle Rogers will be billed at $135 per 55-minute session. Any additional services (consultations with attorneys, psychological reports, letters, and phone calls lasting more than 15 minutes) will be prorated at the hourly rate.
- Fees are due at the time of service and will be billed to the credit card on file.
- You are urged you to call your insurance company to verify your out-of-network mental/behavioral health benefits. Also, ask what your coverage would be for a "90846, 90847, or 90846" billing codes.
- If a pre-authorization is required, you will need to provide a copy of any forms required by your insurance by the date of your consultation (starting February 2023).
- A 24-hour notice must be given for cancellation or rescheduling appointments. The full counseling fee will be assessed for late/no cancellations.

Name of Financially Responsible Party:_____

Client's Name:_____

Client's Date of Birth: _____

Address of Financially Responsible Party:_____

Phone Number of Financially Responsible Party:_____

Email addresses of both Parents:_____

By signing below, I authorize Dr. Gray and Psychological Associates, I understand that Dr. Gray and Psychological Associates is not in-network with any insurance company and I am responsible for checking any pre-authorization requirements and coverage (Starting February 2023) . I understand I will need to provide a copy of any forms required by my insurance by the date of your consultation. I give consent to allow Dr. Gray and Psychological Associates to submit pre-authorizations, when required by the individual insurance company. Further I authorize release of clinical information requested by the health plan to establish "medical necessity" for services and/or to process claims.

Name of Insured: _____

Date*:* _____

Signature*:* _____

 Client's Name: _____

STATEMENT OF CONSENT TO SERVICES

By signing below, I indicate I have read (or have had read to me) all of the information contained in this form, and I fully understand this information. In addition, my signature indicates my consent for "client" to participate in therapy services with Latrelle Rogers, MA, BCBA, with Dr. Glori Gray and Psychological Associates, using Protected Health Information. The information gained from the psychological assessment is to be used for treatment planning purposes during this client's course.

By signing below, I also assume full financial responsibility for fees for therapy services provided by Latrelle Rogers, MA, BCBA, with Dr. Glori Gray and Psychological Associates,. I personally agree to render payment to Dr. Gray and Psychological Associates at the start of services.

Furthermore, this consent can be revoked at any time, although I assume financial responsibility for fees for any services provided prior to revocation of the consent. I am aware of and understand the information contained in the Notice of Privacy Practices, and am aware of my right to access additional copies of this information.

Client's Name:_____

Date:_____

Client / Guardian Signature: _____

 Client's Name: _____

PERMISSION TO RECORD/OBSERVE

Because I am still being supervised by Dr. Glori Gray, a camera is used for recording sessions for review with Dr. Gray. This is for the betterment of your care, as I consult weekly with Dr. Gray on cases.

PERMISSION TO RECORD

I hereby give my permission as the legal guardian for my child for the use of video-recording devices, as well as observation via camera with information stored locally during my session with Dr. Glori Gray & Psychological Associates. I understand that any information obtained during sessions through these means will be used solely for the purpose of supervision and continuity of care between our team, and that otherwise this information will be kept strictly confidential. This authorization will expire on one year form today or when I terminate treatment with this provider. I also understand that any taped material will be summarily erased after this process.

Client/Guardian Signature:_____

 Client's Name: _____

CONSENT FOR TELESERVICES

Telehealth allows the clinician to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. Due to COVID-19 protocols, some or all of your services will be offered virtually during this time. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with Dr. Gray and Psychological Associates.

I understand that while psycho-therapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our sessions could be disrupted or distorted by technical failures, or could be interrupted, or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person treatment and that if the clinician believes I would be better served by another form of psycho-therapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I further attest that since I have chosen this form of treatment, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.

General Considerations:

- Please ensure you are in a private, confidential room to the extent possible, and that others are aware you are in a confidential meeting. It is recommended you hang a sign on your door if you have others in your household who may forget.
- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions. We will use Zoom, and there is a password enabled, as well as a "waiting room" feature to ensure that only those intended for our meeting will be present.
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- Confidentiality still applies for tele-psychology services, and sessions should not be recorded for any reason.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems. We will discuss this at the beginning of our session.
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation. We will discuss this at the beginning of our session.
- If you are under 18, we need the permission of your parent or legal guardian (and their contact information) for you to participate in tele-psychology sessions. They will also sign this agreement below.

Client's Name:_____

Date:_____

Client/Guardian Signature:_____

 Client's Name: _____

SPECIAL CONTRACT FOR PARENTS WHO ARE SEPARATED, PENDING SEPARATION, DIVORCED OR ENGAGED IN LITIGATION

***If this document does not apply to your family, please scroll to the bottom of the section.*
*Please write N/A if this does not pertain to your family.*_____

When a family is confronted by parental separation or divorce, it is very difficult for everyone, especially children. When the parental relationship is conflictual, it is even more important that therapy presents an emotionally safe environment. Our practice wishes to be clear about our position when parents are separated or divorced. We need your agreement that our involvement will be strictly limited to therapy or evaluations that will benefit your child. We do not provide forensic or custody evaluations. Each parent must sign this form.

Please read this document carefully, and do not hesitate to ask me clarifying questions or to express any concerns you have about these or other materials you have received. Nothing contained in this agreement constitutes legal advice. If you have specific legal questions about this document, and how they may relate to your situation, please seek formal legal advice from an attorney. Each parent must sign this document.

In North Carolina, depending on applicable law and the order of any court, both parents (regardless of who holds sole custody) may have the authority to consult with care or treatment providers for their child and request to inspect their child's relevant treatment records. Though therapeutic/counseling records are not considered psychological records, the non-custodial parent may retain rights to verbal updates and consults. HIPAA regulations permit the covered entity (the doctor or health care facility) to provide or deny access to the records when professional judgment is exercised. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns regarding each parent. It is rarely in the child's best interest to have clinical records read by parents. Parents are encouraged to meet regularly with their child's therapist. Arrangements can be made to observe appointments, review records in the office, and freely share information regarding the child's health and treatment, as long as such appointments are compliant with applicable law, court orders, and the professional judgment of the treating provider.

Value Statements:

1. The best treatment for children with emotional and behavioral problems is within the context of their families.
2. Children with divorced parents have ongoing developmental needs for regular contact with both parents, unless it can be shown that this contact threatens the child's safety or mental health.
3. Therapy and testing are confidential, but not secret. Parents are entitled to understand the nature of their child's problem as well as the method and course of treatment.
4. Each profession (Medicine, Psychology, Social Work, Marriage and Family Therapy) is respected with its traditions and ethics.

Procedures:

1. Dr. Glori Gray and Psychological Associates requests a copy of the custody decision for the mental health record, as well as a copy of any court order(s) regarding participation in therapy, contact between a minor child and a parent, or provision for payment of medical and therapy bills.

2. Dr. Glori Gray and Psychological Associates will attempt to involve both parents in the child's care except in cases of abuse or serious impairment on the part of one or both parents, or when theinvolvement would be detrimental to the child's mental health or would interfere with the child's treatment.

3. Parents should understand that telephone, face-to-face, e-mail, or written communication from either parent may be shared as is clinically appropriate at the discretion of the therapist, with the other parent or with the child. Written communications, emails and telephone messages become part of the child's permanent record.

4. North Carolina State Law entitles both parents (regardless of who holds sole custody) the authority to consult with any person who may provide care or treatment for the child and to inspect and receive the child's medical, dental and psychological records, to the same extent as the custodial parent may consult with such person and inspect and receive such records. Though therapy/counseling records are not considered psychological records, the non-custodial parent retains rights to verbal updates and consults. HIPAA regulations permit the covered entity (the doctor or health care facility) to provide or deny access to the records, when professional judgment is exercised. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns regarding each parent. It is rarely in the child's best interest to have therapy records read by parents. Parents are encouraged to meet regularly with their child's therapist. Arrangements can be made to observe appointments, review records in the office, and freely share information regarding the child's health and treatment.

5. The parent/guardian who registers the child for services as a client with Dr. Glori Gray and Psychological Associates is established as the guarantor with this agency/provider and is responsible for payment of the account. When parents who are divorced have agreed to share health care expenses, it is the responsibility of the guarantor of the account to pay the fee and to collect reimbursement from the other parent if sharing expenses. If there is a communication problem resulting in a missed appointment, the guarantor is responsible for payment of the missed appointment fee.

6. Dr. Glori Gray and Psychological Associates expects parents to inform each other about scheduled appointments. The no- show fee will apply if an appointment is missed regardless of which parent scheduled the appointment.

7. Dr. Glori Gray and Psychological Associates is not responsible for routine communication with parents who do not attend appointments. For example, Dr. Glori Gray and Psychological Associates cannot routinely contact the non-custodial parent after each appointment. It is unrealistic to expect a clinician to send a summary letter, note, or e-mail after each appointment, unless payment arrangements have been made for this service. Expectation is that parents will communicate with each other openly regarding treatment and that each parent will cultivate a healthy relationship and open communication with their child.

8. Dr. Glori Gray and Psychological Associates welcomes involvement of step-parents, siblings, grandparents, and others, but participation in sessions and access to the professional is determined based on the child's needs, the parents' wishes, and the family's circumstances. Only parents can have access to

their child's medical records. Both parents have this right of access, regardless of custody unless the custodial parent provides us with a court order limiting access or communication with Dr. Glori Gray and Psychological Associates.

9. Legal issues may arise after therapy and/or evaluations have begun (for example, if one parent decides to change custody status or if there is an attempt to change custody status). Diagnostic evaluations, therapy, versus legal testimony are different skills and rarely should a clinician be involved in more than one role for an individual client. Dr. Glori Gray and Psychological Associates, clinicians with an established working relationship with a child or family, may refuse to render an opinion regarding custody, absent some applicable order of a court of competent jurisdiction. A clinician may cooperate with other professionals by providing information, as appropriate. The priority of the clinician shall be to safeguard confidentiality and preserve their ability to continue working in a healing relationship with the child and family.

By signing this form, I am agreeing to the terms and conditions stated herein.

Guardian's/ Client's Signature: _____

Date: _____

Please provide a contact email for the other parent if parents are no longer in the same home. Once again - North Carolina State Law entitles BOTH parents (regardless of who holds sole custody) the authority to consult with any person who may provide care or treatment for the child and to inspect and receive the child's medical, dental and psychological records, to the same extent as the custodial parent may consult with such person and inspect and receive such records. Though therapeutic/counseling records are not considered psychological records, the non-custodial parent retains rights to verbal updates and consults.

Name and email of other parent: _____

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E: help@drglorigray.com | **F:** (704) 765-4749

 Client's Name: _____

COVID-19 IN-OFFICE APPOINTMENT CLIENT INFORMED CONSENT AND WAIVER

This document contains important information about the decision to resume in-person services in light of the public health crisis caused by COVID-19. Please read this agreement carefully and let your provider know if you have any questions.

DECISION TO MEET FACE TO FACE

Thank you for your trust in our practice. By signing this consent form you are agreeing to meet in person for all or some future sessions. Given the benefits, and inherent risks, in conducting in-person services while COVID-19 remains an active contagion in our society, we wish to address the ways in which we are working to mitigate risk of infection at our offices. We strive to protect you and our staff via hygiene and infection control practices informed by the CDC, EPA, OSHA, WHO, and other guiding organizations. We also ask that you engage in infection control practices to contribute to the health and safety of in-person services, and that you recognize that you are voluntarily choosing to seek in-person services with knowledge of the inherent risks of infection. In addition, at any time, you may speak to your provider if you wish to return to Teletherapy appointments.

OUR PLAN FOR OFFICE SAFETY

Dr. Glori Gray and Psychological Associates takes the health and safety of clients and staff members very seriously. We strive to provide excellent clinical services in the safest possible environment by taking the following measures:

- Clients who are ill will be asked not to come in to our offices. Staff members who show any symptoms of a contagious illness, or who have been in contact with those showing symptoms of COVID-19, or testing positive for COVID-19, will be required to stay home.
- Pre-Screening: On arrival, clients will complete a brief screening to ensure they are symptom-free and have not had close contact with anyone with COVID-19 symptoms.
- Hygiene Practices: Our staff will be practicing infection control hygiene practices, including covering coughs and sneezes, frequent hand washing, and refraining from handshakes.
- Masks: Our building management requires that all people entering the building wear a mask. Our staff will wear masks in common areas.
- Shared Items: We have removed commonly touched items to help minimize transmission of the virus, such as magazines in the waiting room and pillows in therapy offices.
- During Sessions: To minimize virus transmission in session, seating will be arranged to facilitate social distancing of at least six feet where possible; windows can be opened for air ventilation; and each office and waiting room will be equipped with hand-sanitizer, sanitizing wipes, facial tissue, and trash cans for disposal.
- Frequent Sanitizing: Common areas and equipment, such as door knobs, will be sanitized throughout the day, offices will be sanitized between sessions, and therapy and testing materials (e.g,. chairs, tables, waiting room, toys, desks) will be sanitized between use, per CDC guidelines.
- Scheduling: We will be staggering staff schedules where needed to minimize crowding in the office. We ask for your understanding and flexibility if your usual appointment time is impacted by these schedule changes.

YOUR RESPONSIBILITY FOR PROTECTING YOURSELF AND OTHERS

* If you, a family member, or anyone that you have been in contact with in the past 14 days have had symptoms of COVID-19, including fever/chills, coughing, shortness of breath, muscle pain, and/or sore throat, OR tests positive for COVID-19, please do not plan to come into the office. We ask that you take your/your child's temperature at home prior to coming into the office. Anyone with a temperature above normal are asked to reschedule your appointment or change to a Teletherapy session.

* Minimizing Crowding in Waiting Rooms: In order to minimize the number of people and prevent crowding in our waiting rooms we ask that you enter the office at the time of your appointment and not before. Should you arrive early please wait in your car until the time of your appointment. Please come to appointments alone. In the case of young children, please have only one parent or family member accompany them to the office then, when possible, wait in the car until the session is complete. Please do not linger after appointments in our waiting rooms or the hallways.

* Masks: Our building requires anyone entering the building at this time to wear a mask. This applies to all clients and family members who might accompany them to appointments. Please keep masks on in the waiting rooms and all common areas.

* Hygiene: You are encouraged to use bathrooms to wash hands upon arriving for your appointment, hand sanitizer will be available in all rooms, and we ask that clients refrain from touching faces, and maintain social distancing, where possible.

IDENTIFICATION AND NOTIFICATION OF EXPOSURE TO COVID-19

Although we are making every reasonable effort to manage infection risk, and believe that most clients are doing the same, we recognize that some individuals with the virus remain asymptomatic and that there is no way to guarantee that those entering our offices will not be exposed to COVID-19. For public health protection, we ask that any client who has been in our offices and subsequently experiences symptoms of COVID-19, or has been exposed to another person with symptoms of COVID-19, please notify our office immediately so that we can take any additional infection control measures and notify others who have been exposed.

Should we learn that any staff member, client, or household member of anyone who has been in our office has symptoms of COVID-19 or tests positive for the COVID-19 virus, we will notify all individuals who have been in our office in the same time frame of the potential that they may have been exposed. Notifications will be provided to those who had been in our offices and may have come into close contact on the day that the infected individual was also in that office. We will not disclose names or the role of the person infected (e.g., client, janitorial staff, therapist) in an effort to protect confidentiality and privacy.

COVID-19 PROTOCOL COORDINATOR

MariaPaula Chin is our COVID-19 office administrator. She is the contact person to address any questions or concerns and can be reached at 704.765.2549 or help@drglorigray.com. Please contact Maria immediately to report any exposure to or positive test of the COVID-19 virus.

DISCLAIMER

We realize these changes might feel strange or uncomfortable, and that the COVID-19 virus situation may

change in the coming months. We encourage you to speak with your clinician if you have difficulty adjusting to the new health practices. Teletherapy continues to be an option for you at any time if you are not comfortable coming to the office for in-person sessions.

We have procedures in place to mitigate risk per recommended guidelines. However, as with the transmission of any communicable illness, you can still be exposed to COVID-19 at any time. By signing below, you agree to hold Dr. Gray and Psychological Associates harmless in the event that you, or anyone exposed by you, becomes ill with the COVID-19 virus.

Name of Client: _____

Today's Date: _____

Client's Signature: _____

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E: help@drglorigray.com | **F:** (704) 765-4749

Dr. Glori Gray & Psychological Associates

Authorization for Disclosure Form - Primary Care Provider

This form when completed and signed by you, provides authorization for Dr. Glori Gray and Psychological Associates to release/receive protected information from your clinical record to/from the person(s) designated within the document.

Client's Name _____ Client's DOB: _____

I authorize **Dr. Glori Gray** and/or his/her administrative and clinical staff (cross out if not applicable) to release or receive the following information from the records of the above listed client for services provided during the time period of **the last year (or as otherwise relevant)** _____.

(*DGA Therapist's Name*)

Please CHECK item(s) to indicate specific authorization

☐ Evaluation Report	☐ Test Results/Report	☐ Treatment Summary	☐ Treatment Plan
☐ Progress to date	☐ Symptoms	☐ Diagnosis	☐ Prognosis
☐ Other (describe):	☐ Behavioral checklists narrative form and/or description		☐ Functional Status

_____ _____

This information should only be released to or received from:

_____

Name: _____

_____

Organization: _____

PEDIATRICIAN **Address:** _____

_____

Phone:

_____

Email

_____

Name: Dr. Glori Gray

Organization: Dr. Glori Gray and Psychological Associates

Address: 360 N Caswell Rd.
Charlotte, NC 28204

Phone (704) 765-2549

Fax (704) 765-4749

(Please fill in the name and at least email or phone for contact.)

I am requesting my therapist to release or receive this information for the following reason(s):
("at the request of the individual" is all that is required if you are the client and do not desire to state a specific purpose) _____.

This authorization shall remain in effect until _____ (expiration date) or until 1 year from now.

_____

(event related to the individual or the purpose of the use or disclosure)

You have the right to revoke this authorization, in writing, at any time by sending such written notification to CPC's office address. However, your revocation will not be effective to the extent that DGA has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

Client Signature	***Printed Name***	***Date***
Guardian Signature	***Printed Name***	***Date***

Dr. Glori Gray & Psychological Associates
Authorization for Disclosure Form- Other

This form when completed and signed by you, provides authorization for Dr. Glori Gray and Psychological Associates to release/receive protected information from your clinical record to/from the person(s) designated within the document.

Client's Name _____ Client's DOB: _____
I authorize **Dr. Glori Gray** and/or his/her administrative and clinical staff (cross out if not
(*DGA Therapist's Name)*
applicable) to release or receive the following information from the records of the above listed client for services provided during the time period of **the last year (or as otherwise relevant)** _____.

Please CHECK item(s) to indicate specific authorization

☐ Evaluation Report	☐ Test Results/Report	☐ Treatment Summary	☐ Treatment Plan
☐ Progress to date	☐ Symptoms	☐ Diagnosis	☐ Prognosis
☐ Other (describe):	☐ Behavioral checklists narrative form and/or description		☐ Functional Status

_____ _____

This information should only be released to or received from:

(Please fill in the name of the school and at least phone for contact.)

Name: _____
_____
Organization: _____
Address: _____
_____
Phone: _____
Email: _____

Name: Dr. Glori Gray
Organization: Dr. Glori Gray and Psychological Associates
Address: 360 N. Caswell Rd.
Charlotte, NC 28204
Phone (704) 765-2549
Fax (704) 765-4749

I am requesting my therapist to release or receive this information for the following reason(s):
("at the request of the individual" is all that is required if you are the client and do not desire to state a specific purpose) _____.
This authorization shall remain in effect until _____ (expiration date) or until 1 year from now .

You have the right to revoke this authorization, in writing, at any time by sending such written notification to CPC's office address. However, your revocation will not be effective to the extent that DGA has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____

Client Signature **Printed Name** **Date**

_____

Guardian Signature **Printed Name** **Date**

 Client's Name: _____

RIGHT TO RECEIVE A GOOD FAITH ESTIMATE OF EXPECTED CHARGES UNDER THE "NO SURPRISES ACT"

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

* You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

* Make sure your health care provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your health care provider, and any other provider you choose for a Good Faith Estimate before you schedule an item or service.

* If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

* Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call your provider directly.

Guardian/Client's Initials:_____
Please initial that you have understood the statements above. By signing this form, you are agreeing to the terms and conditions stated herein.

GOOD FAITH ESTIMATE FOR HEALTH CARE AND HEALTH CARE ITEMS AND SERVICES with Latrelle Rogers, MA, BCBA

Ms. Rogers provides therapy every other week, primarily on Monday's and Wednesday's. If you have a need outside of this, please communicate with her about your desire for a different day or for alternate options (e.g.., once or twice per week). She will communicate about whether that would be clinically useful and/or appropriate given your child's needs at this time.

If scheduled, list the first date the Primary Service or Item will be provided or put "N/A" if not yet scheduled:_____

Put today's date as the start of the Date of the Good Faith Estimate: _____
The Estimated Cost: $135/session x 3 months (6 sessions) = $810

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

Client/Guardian Signature: _____
By signing this form, you are agreeing to the terms and conditions stated herein.

 Client's Name: _____

Dr. Glori Gray & Psychological Associates
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You will receive an emailed copy of this document. Please keep it in a safe place or take pictures of it.

THANK YOU FOR COMPLETING THIS DOCUMENT.

Thank you for your time with this! We really appreciate it and look forward to working with you! If you have any questions or concerns, please do not hesitate to contact our office.

If you are a new client of ours, please do not forget to complete the Client Intake Form. Go to this link to access it: https://rb.gy/tflqkt

Thank you!

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