Name: _____ DOB: _____ Date: _____

Provider: Carolyn Ballantine, MD

Receipt of Notices and Request for Services

_____ I have read the attached Professional Disclosure Statement : Carolyn Ballantine, MD, an employee of LifeCare Counseling and Coaching.

_____ I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____ I hereby request professional services from this professional. I understand the first one or two visits are for evaluation purposes and are not a guarantee of further treatment. If ongoing treatment at this office is indicated and mutually agreeable then a treatment plan will be agreed upon at the end of the evaluation.

Financial Responsibility

_____ I hereby unconditionally guarantee payment to LifeCare Counseling and Coaching for all costs, charges and expenses incurred by said patient at this office, unless separate arrangements are agreed upon in writing. I agree to have my credit card number on file for payment and authorize that card to be used to cover any unpaid balances.

_____ I also agree to pay a service charge of $40.00 for any checks that are returned unpaid. I understand if the patient balance for services provided is not paid within thirty days of billing date, the amount due will be deemed delinquent.

For when the card on file does **not** belong to the patient: I, the financially responsible one, _____ _____
(Print Name) (Signature)
give complete permission that the costs incurred by _____ and any outstanding balances now and going forward may be collected by LifeCare using my credit card number. (Patient Name)

Insurance/Third Party Payment

_____ I understand it is my responsibility to inform the office of any changes in my insurance, prior to the effective date of the change and accept financial responsibility for any office charges that were incurred prior to this date.

____ If I have third-party reimbursement, I understand it is only for the services they have agreed to cover. I understand that any additional services I desire are being provided outside this insurance arrangement, and I accept full financial responsibility for these services.

____ I certify the following information to be accurate: (Check **one** below)

___ 1) **No Insurance.** I have no insurance, or request that no insurance claims be filed by the office. I will accept full financial responsibility for any services the office provides.

___ 2) **Using Insurance, but Out of Network.** I have insurance/third party coverage with:

_____. I understand there is not a contract between this payer and the office for this provider's services. I accept financial responsibility for my bill regardless of whatever action my insurer takes. I request that claims be files with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office.

___ 3)**Contract with Insurance/In-network.** I have insurance/third party coverage with:

_____. I understand there is a contract between this payer and the office for this provider's services. I accept responsibility for any deductibles and co-payments specified by this contract. I request that claims be filed with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office. I accept financial responsibility for any services I desire that are not covered by my insurer.

_____ _____
Patient Date

_____ _____
Legally Responsible Person Date

_____ _____
Provider Date

1601 Jones Franklin Road, Suite 104, Raleigh, NC 27606 TEL (919) 851-1527 Fax (919) 851-3555

Carolyn Ballantine, MD
Professional Disclosure Statement

Credentials

Bachelor of Arts, Princeton University, 1991
M.D., Vanderbilt University, 1999
Internship, University of North Carolina Hospitals, 1999-2000
Psychiatry residency, Duke University, 2000-2003
Diplomate, American Board of Psychiatry and Neurology, since 2004

Professional Experience and Services

Inpatient and outpatient psychiatric treatment of adults since 2003, including therapy and medication management.

Fee Schedule

Complete Diagnostic Interview 45-60 minutes (90792)	$215
Complete Diagnostic Interview 75-90 minutes	$265
Medication Management 10-15 minutes (99XXX)	$95
Psychotherapy with evaluation and medication management 20-30 min (99XXX)	$140
Psychotherapy with evaluation and medication management 45-50 min (99XXX)	$180
No-Show	Full Fee
Late-Cancellation	One-half of full fee
Telephone Consultation ≤ 5 minutes	No charge
Telephone Consultation > 5 minutes	Based on time required
Reports and Letters	Appointment required
Photocopying	Based on number of pages
Court Preparation/Appearances	$300 per hour

Payment, Insurance Reimbursement, and Problem Resolution

It is our policy to receive payment for services at the time they are provided. Cash, personal checks, credit and debit cards are acceptable forms of payment. As a convenience to you, we will file your claim with your insurance company. If you are unable to keep an appointment, please call to cancel the business day prior 24 hours before your appointment. Less than that will be considered a late- cancellation. No call or not coming to your appointment will result in a No-show fee. No-show and late-cancellation fees are listed above.

At LifeCare, we are committed to provide you with excellence in Christian psychiatry and counseling. Our psychiatrist and counselors are well-trained, board certified, and experienced in dealing with a wide variety of needs. We sincerely appreciate the opportunity to help you with your current concerns.

We are in-network providers with Blue Cross Blue Shield of North Carolina, except for Blue Local plans. Some of our providers are also in-network with United Healthcare and Cigna, but not all. Please check with your provider regarding whether they are in-network for your plan. Please be aware that some insurance companies contract mental health benefits out to a different insurer who may be out-of-network. Your insurance company can confirm your benefits.

We are out-of-network providers for all other insurance plans. As a convenience to you we will make every effort to file a claim on your behalf. If we are not able to file the claim we will provide you with the appropriate forms so you may file the claim yourself. We ask for the full fee at the time of service, then file the claim and assign payment of any benefits to come directly to you personally. We are not accepted providers for Medicaid or Medicare.

If you are dissatisfied with any aspect of the services provided by me, please inform me so that we can address your concerns. If we cannot come to a satisfactory resolution, you may speak further with me or with Maria Lyons, Office Manager. If after doing so you are still dissatisfied, you may contact the NCMB at PO Box 20007, Raleigh, NC 27619-0007.

COURT PREPARATION/APPEARANCES:

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement and clinical schedule readjustments, I charge $300 per hour for preparation and attendance at any legal proceeding. (You will be held responsible for payment for the professional time required even if I am compelled to testify by another party. An agreed upon amount will be rendered *in advance* and held in escrow. Any leftover amounts will be returned to you upon resolution of the legal matter.)

CONFIDENTIALITY

The confidentiality of your personal health information is very important to us. We may use and disclose your personal information without authorization for the following purposes: abuse, neglect, domestic violence or court order.
As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse to self or others, neglect, domestic violence, or court order. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Please see "Notice of Privacy Practices" for more detailed information about confidentiality of service and records.

_____ _____

Patient Date

_____ _____

Provider Date