OakTree Counseling: Stephanie Adams-Gilmer, LCSW

211 S. Salem St. Suite B, Apex, NC 27502
574-527-8731
Stephanie.adams.gilmer@outlook.com

Directions to the office---

From Raleigh:

- Take the Beltline towards Holly Springs
- Take US 1 South towards Sanford
- Take Exit 95 and turn left towards Holly Springs. (You are on 55/Williams Street)
- Continue straight, but get in the right lane.
- Turn right at the traffic light and stay in right lane.
- Continue on Williams St./55 until you go under a viaduct and turn right at first light. (Salem St.)
- Go two blocks and turn right onto Moore St. Parking lot is on your left. Building is gray with black awning.

*Sometimes traffic on Hwy 55 into Apex is slow moving. You may want to consider taking the exit for Ten-Ten Rd (Exit 96), turning left onto Center St. and then left again onto Salem St. My office will be on the left after you've passed through downtown Apex.

From Fuquay Area:

- Take 55 Bypass towards Holly Springs.
- Continue through until you enter Apex and pass over US 1.
- Stay in right lane. Continue on Williams St./55 until you go under a viaduct and turn right at first light. (Salem St.)
- Go two blocks and turn right onto Moore St. Parking lot is on your left. Building is gray with black awning.

PLEASE CALL IF YOU NEED ASSISTANCE WITH FINDING MY LOCATION!

OakTree Counseling: Stephanie Adams-Gilmer, MSW, LCSW

Demographic Information Sheet

Name: _____
Email Address:_____
Phone: _____ Okay to leave a message? Yes No
Daytime_____ Okay to leave a message? Yes No
Evening_____ Okay to leave a message? Yes No
Cell_____ Okay to leave a message? Yes No
Client Address:

_____

_____

Marital Status: _____
Employment Status: _____
Place of Work: _____
Position: _____
Birth date: _____
SSN#_____
Sex: M F
Responsible Party:

_____
Address:

_____

_____
If Different from client:
Home Phone: _____ Work Phone: _____
How did you find my name?

_____

Insurance Information:

Insurance Company Name:

_____

Claims Address:

_____

_____

Policy Holder Name:

_____

Policy Holder Address:

_____

_____

Relationship to Insured:

_____

Are you under your employer's health plan? _____

ID #_____

Group Number_____

Policy Number _____

Employer: _____

Date of Birth: _____

Home Phone: _____

Work Phone: _____

Consent for Treatment

I, the undersigned, have voluntarily applied for and agree to participate in counseling, psychological, and/or psychiatric services.

Please initial:

_____I hereby authorize Stephanie Adams-Gilmer, LCSW to release treatment and psychological information to my primary medical physician and health insurance carrier if necessary. I understand that I am fully responsible for all fees relating to my treatment, and I further agree to pay my co-payment at the time of each visit.

_____**In the event that I miss an appointment or cancel an appointment with less than 24 hours notification*, I understand that I am solely responsible for paying a $75 fee.** Furthermore, if I fail to appear for three consecutive scheduled appointments my case will be placed on inactive status.
If you cancel your appointment via email do not assume it is cancelled until you have gotten a confirmation reply from me. I will note the time you sent it and cancel as long as you have given at least 24 hours' notice in advance of your appointment.

Signed: _____

Printed Name: _____

Date: _____

Court Testimony Agreement

It is in your best interest to know that conducting expert witness/testimonial services in a court setting is not in my area of interest of expertise. If you have suspicion that your case will be going to court and you will need therapist testimony, please let me know so I can provide you with an appropriate referral source that can meet your needs.

Should you subpoena Stephanie Adams-Gilmer, LCSW with or without approval or involve me in court related processes, you agree to pay a retainer fee of $2,400 that is due at the time a subpoena is served. The charge for court-related services of any kind is $300 per hour, including case preparation, witness time, and any wait time related to a court related process. Fees incurred for these services will not be filed with your insurance company.

Please keep in mind that a court ordered subpoena will terminate protection of client-therapist privilege and the duty to maintain confidentiality.

By signing below, I acknowledge and agree to this agreement. I will provide a copy to you for your record and will retain a copy in my confidential records.

_____ _____

Client Signature Date

Payment Agreement

YOU ARE EXPECTED TO PAY YOUR CO-PAY, DEDUCTIBLE, CO-INSURANCE AND ANY PAST DUE BALANCE ON YOUR ACCOUNT AT THE TIME OF SERVICE. THANK YOU.

You may pay by cash, check, credit card, or debit card. Please read the following and sign at the bottom to accept these terms.

I _____, agree to pay my co-payment, deductible, co-insurance, and any past-due balance on my account at the time of service.

Signed_____ Date:_____

I would like to keep a credit or debit card on file that will be automatically billed at the end of each session:

Card # _____

Expiration Date:_____

Name on Card_____

Type of Card: Debit_____ Credit_____

Three-digit code on the back_____

Zip Code_____

I authorize Stephanie Adams-Gilmer, LCSW to charge any past due balances on my account to the above debit or credit card number on a monthly basis.

Signed_____

Date:_____

OakTree Counseling: Stephanie Adams-Gilmer, LCSW

NOTICE OF PRIVACY PRACTICES – Brief Version

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.

Commitment to Your Privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I also am required by law to keep your information private. These laws are complicated, but I must give you this important information. This pamphlet is a shorter version of the full, legally required Notice of Privacy Practices ("NPP") and you may have a copy of this to read and refer to it for more information.

I will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP, I will ask you to sign a consent form to let me use and share your information in an appropriate manner. If you do not consent and sign this form, I cannot treat you.

If I or you want to use or disclose (send, share, or release) your information for any other purposes, I will discuss this with you and ask you to sign an authorization form to allow this. Of course I will keep your health information private but there are some times when the laws require me to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are other situations like these but which do not occur very often. They are fully described in the longer version of the NPP.

Your Rights Regarding Your Health Information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information I have about you such as your medical and billing records, with the exception of psychotherapy notes. You can even get a copy of these records but I may charge you.
4. If you believe the information in your records is incorrect or missing important information, you can ask me to make changes to (or amend) your health information. You have to make this request in writing. Please provide the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. Filing a complaint will not change the health care I provide to you in any way.

The effective date of this notice is April 1, 2015
.
Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

OakTree Counseling: Stephanie Adams-Gilmer, LCSW

211 S. Salem St. Suite B
Apex, NC 27502

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"
You may refuse to sign this acknowledgement

On this date, I, _____
received a copy of the brief version of Stephanie Adams-Gilmer, LCSW "Notice of Privacy Practices" to protect the privacy of my health information. I am aware that I may request the full length "NPP" to review at any time by requesting a copy from any staff member.

_____

Signature of Client Date

_____

Witness