JAMES M. BARRY MSW, LCSW
PO BOX 9728
FAYETTEVILLE, NC 28311

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CLIENT NAME:_____
(LAST) (FIRST) (M.I.)

ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

TELEPHONE #:_____WORK #:_____
FAX #:_____E-MAIL:_____
EMPLOYER:_____
(IF CLIENT IS MINOR, PLEASE GIVE PARENT'S EMPLOYER)

D.O.B. :_____MARITAL
STATUS:_____SSN_____
EMERGENCY CONTACT
PERSON:_____
(NAME) (PHONE #)

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INSURANCE INFORMATION (If Tricare, see below)

NAME OF PRIMARY INSURANCE
CO._____
INSURANCE CO. ADDRESS:_____
TELEPHONE #:_____GROUP PLAN
NAME:_____
INS. ID #_____INSURED'S NAME:_____
NAME OF SECONDARY INSURANCE CO._____
INSURANCE CO. ADDRESS:_____
TELEPHONE #:_____GROUP PLAN NAME:_____
INS. ID#_____INSURED'S NAME:_____

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PLEASE COMPLETE IF YOU ARE COVERED BY TRICARE:

SPONSOR NAME:_____RELATIONSHIP TO
PATIENT:_____
SPONSOR ID #:_____RANK:_____BRANCH:_____
ACTIVE DUTY OR RETIRED:_____
TRICARE STANDARD PPO OR TRICARE PRIME HMO?:
_____
IF TRICARE PRIME, IS YOUR PRIMARY CARE PHYSICIAN LOCATED ON BASE OR A CIVILIAN LOCATED OFF BASE?: (CIRCLE ONE) ON BASE OFF BASE

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION OBTAINED DURING EVALUATIONS OR TREATMENT OF THIS CLIENT TO THE INSURANCE COMPANY INDICATED ABOVE WHICH IS
NECESSARY TO EXPEDITE AND SUPPORT ANY INSURANCE CLAIMS ON THIS ACCOUNT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. I AUTHORIZE THE PAYMENT OF BENEFITS DIRECTLY TO THIS PROVIDER.

CLIENT'S/PARENT'S/GUARDIAN'S:

SIGNATURE:_____DATE:_____

JAMES M BARRY MSW, LCSW

Client:_____ Record Number:_____

HIPAA

(Health Insurance Portability and Accountability Act)

Providers have always protected the confidentiality of health information by stealing medical records away and cabinets and refusing to reveal your information. Today, state and federal laws attempt to ensure the confidentiality of the sensitive information. As a provider, I also follow all state guidelines on confidentiality.

The federal government has published regulations designed to protect the privacy of your health information. This privacy rule protects health information that is maintained by physicians, hospitals, other health care providers and health plans.

This regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician or therapist, are admitted to the hospital, Philip prescription or send a claim to a health plan, your position, the hospital or other health care provider will need to consider the privacy rule. All health information including paper records, oral communication and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions, these rights are not absolute. I also take precautions in my office to safeguard your health information. Please feel free to ask me about exercising your rights or how your health information is protected in my office.
Sincerely,
James M. Barry MSW, LCSW

I have read the Notice of Privacy Practices.
Client/Guardian:_____
Date:_____

CONSENT TO RELEASE INFORMATION FORM

JAMES M BARRY MSW, LCSW

Authorization to Disclose Information

This is to be filled out with your health insurance company information.

I, _____, hereby authorize
Name of person giving consent
James M Barry to release to _____
Name of Insurance Company
Information related to my treatment, including HIV and substance abuse, and if necessary, photocopies of any medical records which may be required or useful for continuity of coordination of my treatment.

Unless otherwise notified, this consent will expire twelve months from the date signed.

However, I do reserve the right to withdraw this authorization at any time.

Signature of person giving consent: _____
Address:_____
(Street) (City) (State) (Zip code)

Telephone Number:_____
Date:_____

INFORMED CONSENT FOR TELE-THERAPY

James M. Barry MSW, LCSW

Name _____ Date of Birth _____

1. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. Any personal information you choose to share with me will be held in the strictest confidence. Just as for my face-to-face clients, I will not release your information to anyone without your prior approval, or I am required to do so by law.
There are specific and limited exceptions to confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

2. You understand that our Teletherapy occurs in the state of North Carolina, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit me in my North Carolina office, where we meet to do our work.

3. You understand that our Teletherapy is neither a universal substitute, nor the same as face-to-face psychotherapy treatment. You accept the distinctions made using Teletherapy vs. face-to-face psychotherapy. In particular, you accept that Teletherapy does not provide emergency services.

4. You are responsible for information security on your computer. If you decide to keep copies of our emails or communication on your computer, it's up to you to keep that information secure. Unfortunately, I cannot guarantee the security of our emails as they travel between our computers. It is possible, though unlikely, to intercept emails in transit. If you are concerned about that possibility, please consider the option to encrypt our emails. Even if someone were to intercept an encrypted email, they would not be able to read the encoded message.

5. Our Teletherapy is a means by which you, the e-client, can receive coaching, counseling, information and guidance from a psychotherapist. It is perhaps most accurately perceived as a process creating, over time, a trusting and collaborative relationship. In our collaboration, you retain the right to determine which topics we cover and the depth of consideration each receives. In other words, as an e-client, you are free to contribute or withhold any information you choose. Moreover, you are under no obligation to apply information and/or opinions I contribute to our Teletherapy. While I hope that you will find our exchange useful in your efforts to help yourself and improve your life, it is not possible to guarantee that. Despite the ever-increasing positive feedback from e-clients, Teletherapy therapy is best considered experimental until its efficacy has been validated scientifically.

Telecommunication: Telehealth (e-therapy) is the use of electronic transmissions to treat the needs of a patient. In this case, we offer both video and audio forms of communication via the Internet and/or telephone. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.
The risks involved with Telehealth include the potential release of private information due to the complexities and abnormalities involved with the Internet. Viruses, Trojans, and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, there is the risk of being overheard by anyone near you if you do not place yourself in a private area and are open to other's intrusion.

I understand that while teletherapy may provide significant benefits, it may also pose risks. Teletherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories.

Client/Patient Signature and Date_____
Therapist Signature and Date _____

Be advised all parties that will be participating in therapy will need to sign this page. For that reason, here are some extra signature lines.
Signature_____
Date_____
Signature_____
Date_____