



## **Intake Form**

**Instructions:** Please fill out this form prior to your first session. Your information will remain confidential and is essential for us to provide you with the best possible care. Thank you for choosing Teatime With Khi, PLLC.

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### **Personal Information:**

- **Full Name:**
- **Address:**
  - Street:
  - City:
  - State:
  - Zip Code:
- **Age:**
- **Date of Birth:**
- **Gender:**
- **Race:**
- **Ethnicity:**



## **Intake Form**

### **Contact Information:**

- **Phone Number:**
  
- **Email Address:**

### **Emergency Contact Information:**

- **Full Name:**
- **Relationship to You:**
  
- **Phone Number:**
  
- **Email Address:**

### **Referral Information:**

- **How did you hear about Teatime With Khi, PLLC? (Social Media, Psychology Today, Therapy For Black Girls, Word of Mouth, etc.)**

### **Therapy Goals:**

- **What are your goals for therapy?**

### **Current Issues/Symptoms:**

- **Please describe any current issues or symptoms you are experiencing:**



### **Intake Form**

**Reason for Seeking Services:**

- **Why are you seeking services through Teatime With Khi, PLLC?**

**Have you previously seen a therapist, psychiatrist, or other mental health professional?**

- Yes
- No

**If you answered yes to the question above, please briefly explain when and for what reason you previously saw a therapist, psychiatrist, or other mental health professional.**

**Have you ever received a formal mental health diagnosis from a mental health professional?**

- Yes
- No

**If you answered yes to the question above, please briefly explain the diagnosis and the approximate date of diagnosis you received from a mental health professional.**



## **Intake Form**

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### **Consent and Acknowledgment:**

By signing below, I acknowledge that the information provided is accurate and complete to the best of my knowledge. I consent to the use of this information for my treatment at Teatime With Khi, PLLC.

The information collected in this intake form is intended to gather general information about you. Please note that this form is not a comprehensive assessment. Upon initiation of services, you will undergo a full biopsychosocial assessment to thoroughly evaluate your mental health, medical history, and social circumstances. This detailed assessment will help us develop a personalized treatment plan tailored to your specific needs and goals.

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Please sign and date below to acknowledge that you have read and understood your financial responsibilities and the instructions provided above.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name: \_\_\_\_\_



## **HIPAA and Informed Consent**

### **1. HIPAA Notice and Consent**

**1.1 Understanding HIPAA:** The Health Insurance Portability and Accountability Act (HIPAA) is a federal law designed to protect the privacy and security of your health information. Teatime With Khi, PLLC is committed to maintaining the confidentiality of your personal and health information. This includes safeguarding your records from unauthorized access and using your information solely for the purpose of providing, managing, and billing for your treatment.

**1.2 Use and Disclosure of Information:** Your health information may be used and disclosed for treatment, payment, and healthcare operations as permitted by HIPAA. This includes sharing information with other healthcare providers involved in your care, billing your insurance company, and other administrative activities. We will obtain your consent before disclosing your information for any purpose beyond those required by law.

**1.3 Your Rights:** You have the right to review and obtain copies of your health records, request corrections, and obtain a detailed accounting of disclosures. You also have the right to request restrictions on how your information is used or disclosed, although we are not required to agree to all such requests.

**1.4 Changes to Privacy Practices:** We may update our Notice of Privacy Practices from time to time. You will be notified of any significant changes and provided with a revised notice. You may also request a copy of our current Notice of Privacy Practices at any time.

### **2. Consent to Treatment**

**2.1 Consent to Receive Treatment:** By signing this form, you consent to receive mental health treatment from Teatime With Khi, PLLC. This includes consenting to the use of evidence-based therapeutic practices tailored to your needs. You understand that no guarantees are made regarding the outcomes of treatment.



## **HIPPA and Informed Consent**

**2.2 Right to Withdraw Consent:** You have the right to withdraw your consent and discontinue treatment at any time. If you choose to do so, please notify us in advance to facilitate an appropriate conclusion to your care.

### **3. Telehealth Services**

**3.1 Telehealth Policy:** Teatime With Khi, PLLC provides services exclusively via telehealth, which includes online video and/or phone consultations. You consent to participate in mental health treatment through these telehealth methods, understanding that these services are delivered over the internet or by phone and are subject to potential limitations such as technical issues or interruptions.

**3.2 Technical Requirements:** For online video sessions, you will need a stable internet connection, a computer or mobile device with a camera and microphone, and a private, secure location to ensure the confidentiality of your sessions.

**3.3 Confidentiality and Security:** We use secure platforms to conduct telehealth sessions, but there are inherent risks to electronic communications. We strive to maintain the confidentiality and security of your information and use platforms that comply with HIPAA standards.

**3.4 No Driving During Sessions:** For your safety and to ensure effective treatment, you must be in a stationary, safe location during telehealth appointments. We will not conduct sessions if you are driving or operating a vehicle.

### **4. Acknowledgment and Agreement**

By signing this form, you acknowledge that you have read, understood, and agree to the terms outlined above. You consent to the use of telehealth services and authorize Teatime With Khi, PLLC to use and disclose your health information as described. You also understand and accept the telehealth requirements and policies.



## **HIPPA and Informed Consent**

### **Client Information:**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for your cooperation and for choosing Teatime With Khi, PLLC. We look forward to supporting your mental health and well-being.



## **Practice Policy and Consent Form**

**Welcome to Teatime With Khi, PLLC.** This Practice Policy Consent Form outlines our policies regarding privacy practices, payment, informed consent, and cancellations. By signing this form, you acknowledge your understanding and acceptance of these policies.

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### **1. Notice of Privacy Practices**

**1.1 Use and Disclosure of Information:** Teatime With Khi, PLLC is committed to protecting your privacy. We use your identifiable health information for the purposes of providing and managing your mental health care. This information may include personal details, treatment records, and billing information. We may disclose this information to other healthcare providers involved in your care, insurance companies for billing purposes, and as required by law. We will not disclose your information without your explicit consent except as required for treatment, payment, or operational purposes.

**1.2 Changes to Privacy Practices:** We reserve the right to change our privacy practices at any time. Any changes will be communicated to you through written notice. You will be given a copy of the updated Notice of Privacy Practices upon request.

### **2. Payment Policy**

**2.1 Cost of Services:** At Teatime With Khi, PLLC, individual therapy sessions are priced at \$150 per session, and couples therapy sessions are \$175 per session. Payment is due at the time services are rendered. In compliance with the No Surprises Act, we provide Good Faith Estimates to all clients, ensuring transparency in healthcare costs. These estimates outline the expected charges for services provided. As a practice located in North Carolina, we are committed to providing clear and accurate information regarding the cost of care to prevent any unexpected expenses.

Teatime With Khi, PLLC  
722 Cedar Point Blvd, #227  
Cedar Point, NC 28584  
910-939-1110  
khiana@teatime2.com





## **Practice Policy and Consent Form**

**2.2 Insurance and Billing:** It is your responsibility to verify and understand your insurance coverage, including co-payments, deductibles, and any services not covered by your plan. Teatime With Khi, PLLC will assist with billing procedures but cannot guarantee payment from your insurance company. Any fees not covered by insurance will be your responsibility.

**2.2 Payment Methods:** Payments are due at the time of service. Your card on file will be charged for any copayments and fee for services. Should there be insufficient funds on the card on file, you will be notified. Failure to remit payment may result in your appointment being cancelled.

**2.3 Third Party Services:** At Teatime With Khi, PLLC, we utilize third-party billers such as Simple Practice, Headway, Alma, and Grow Therapy to assist with our billing services. As a result, individuals may see charges from these organizations on their billing statements. By signing and agreeing to this form, you acknowledge and understand that your information may be shared with these third parties to facilitate billing and payment processes. This collaboration ensures efficient and accurate handling of your billing needs. If you have any questions or concerns regarding this policy, please feel free to reach out to our administrative staff for further clarification.

## **3. Informed Consent**

**3.1 Understanding Treatment:** By signing this form, you consent to participate in mental health treatment with Teatime With Khi, PLLC. This includes agreeing to the use of evidence-based therapeutic practices and acknowledging that no guarantees can be made about the outcomes of treatment.



## **Practice Policy and Consent Form**

**3.2 Right to Withdraw:** You have the right to withdraw consent and discontinue treatment at any time. Should you choose to do so, please notify us in advance so that appropriate arrangements can be made for the conclusion of your care.

### **4. Additional Privacy Policies**

**4.1 Confidentiality:** All information shared during sessions is confidential except in cases where disclosure is required by law, such as in situations of suspected abuse, threats of harm to yourself or others, or legal proceedings. Please refer to the following examples in which confidentiality may be broken:

- If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
- If a client threatens grave bodily harm or death to another person.
- If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
- Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
- Suspected neglect of the parties named in items #3 and # 4.
- If a court of law issues a legitimate subpoena for information stated on the subpoena.
- If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.



## **Practice Policy and Consent Form**

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

**4.2 Communication:** Teatime With Khi, PLLC is committed to reaching out to clients in a timely manner. We will make every effort to respond to your messages, calls, and emails as promptly as possible during business hours. However, if you are experiencing a mental health crisis or emergency, please call 911 or go to the nearest emergency room immediately. This practice is not equipped to handle emergencies or provide immediate assistance outside of scheduled sessions.

**4.3 Social Media:** To maintain appropriate professional boundaries, Teatime With Khi, PLLC will not accept friend requests, follow clients, or interact with clients on social media platforms. This policy is in place to preserve the confidentiality of your treatment and to maintain a clear separation between your personal and therapeutic lives.

**4.4 Online Video Appointments:** All telehealth services provided by Teatime With Khi, PLLC will be conducted via secure online video platforms. Please ensure you have a stable internet connection and a private space to participate in your sessions. It is important that you choose a safe and secure location for your telehealth appointments where you will not be interrupted or overheard by others.

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## **Practice Policy and Consent Form**

**4.5 No Driving During Sessions:** For your safety and to ensure the effectiveness of your treatment, Teatime With Khi, PLLC will not conduct telehealth sessions with individuals who are driving or operating a vehicle at the time of their appointment. Please ensure you are in a stationary, safe location before beginning your session.

### **5. Cancellation and No-Show Policy**

**5.1 Appointment Cancellation:** If you need to cancel or reschedule an appointment, please provide at least 24 hours' notice. This allows us to offer the time slot to other clients who may need it.

**5.2 No-Show Fees:** If you do not arrive within 15 minutes of your scheduled appointment time, you will be considered a "no-show." As a result, you will be billed for the full appointment fee of \$150.

**5.3 Emergency Cancellations:** In cases of emergency or unforeseen circumstances, please inform us as soon as possible. We will make reasonable accommodations to reschedule your appointment.

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### **Acknowledgment and Agreement**

I have read, understood, and agree to the policies outlined in this Practice Policy Consent Form. I acknowledge that I have been provided with a copy of Teatime With Khi, PLLC's Notice of Privacy Practices and that I understand how my personal and health information will be used and disclosed.



## **Practice Policy and Consent Form**

### **Client Information:**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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Thank you for choosing Teatime With Khi, PLLC. We look forward to supporting your mental health and well-being.

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## **Consent for Telehealth Sessions Using Simple Practice**

Teatime With Khi, PLLC uses a third-party service called Simple Practice to conduct telehealth sessions. This platform allows us to offer remote therapy services, ensuring convenience and flexibility for our clients.

### **Pros and Cons of Telehealth Services**

#### **Pros:**

- **Convenience:** Attend sessions from the comfort of your home or any private location.
- **Accessibility:** Access mental health services regardless of geographic location.
- **Flexibility:** Schedule sessions more easily around your personal and professional commitments.
- **Safety:** Reduce exposure to contagious illnesses by avoiding in-person visits.

#### **Cons:**

- **Technical Issues:** Potential for internet connectivity problems or software malfunctions.
- **Privacy Concerns:** Risk of privacy breaches if sessions are not conducted in a secure, private location.
- **Limited Non-Verbal Cues:** Lack of physical presence may limit the therapist's ability to interpret body language and other non-verbal cues.
- **Emergency Limitations:** Telehealth services are not suitable for managing crises or emergencies.



## **Consent for Telehealth Sessions Using Simple Practice**

### **Consent to Telehealth Services**

By signing this form, you are consenting to receive telehealth services from Teatime With Khi, PLLC. You acknowledge and understand the benefits and limitations of telehealth as outlined above.

### **Consent to Use Simple Practice**

Additionally, by signing this form, you are consenting to the use of Simple Practice as the platform for conducting telehealth sessions. You understand that Simple Practice is a third-party service provider and not responsible for delivering healthcare services. In the event of an emergency, you should contact emergency services or go to the nearest emergency room.

If you have any questions or concerns about this consent form or the use of telehealth services, please don't hesitate to reach out.

**BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.**

### **Client Information:**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for choosing Teatime With Khi, PLLC. We look forward to providing you with quality care and support.

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## **Client Insurance Responsibility and Billing Information Form**

Thank you for choosing Teatime With Khi, PLLC for your mental health care needs. This form is designed to help you understand your financial responsibilities and how to navigate your insurance coverage effectively.

### **1. Understanding Your Insurance Coverage**

It is your responsibility to be aware of your insurance coverage, including mental health benefits, copayments, deductibles, and telehealth services. To ensure that you have accurate and up-to-date information, we recommend contacting your insurance company directly.

### **2. How to Contact Your Insurance Company**

When contacting your insurance company, please follow these steps:

#### **a. Gather Your Information:**

- Insurance card
- Policy number
- Personal identification

#### **b. Questions to Ask Your Insurance Company:**

- What are my mental health benefits?
- What is my deductible, and how much of it have I met?
- What is my copayment for outpatient mental health services?
- Are telehealth services covered under my plan?
- Are there any session limits for mental health services?
- Are the CPT codes 90791 (initial evaluation) and 90837 (individual therapy session, 53 minutes) covered under my plan?

#### **c. Important Tips:**

- Always ask for a reference number for the call. This will be useful for future reference or follow-up.
- Take detailed notes during the call, including the name of the representative you spoke with and the date of the conversation.





## **Client Insurance Responsibility and Billing Information Form**

### **3. Billing Process**

Teatime With Khi, PLLC will either bill your insurance company directly for services provided or use a third-party company (i.e. Headway, Alma, etc.) in order to do so. This includes:

- **90791:** Initial evaluation
- **90837:** Individual therapy session (53 minutes)

Please be aware that any copayments, coinsurance, or deductibles required by your insurance plan are your financial responsibility.

Thank you for your attention to this important matter. We appreciate your cooperation and look forward to providing you with the best possible care.

**Sincerely,**

Teatime With Khi, PLLC

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Please sign and date below to acknowledge that you have read and understood your financial responsibilities and the instructions provided above.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name: \_\_\_\_\_

By signing this form, you agree to the terms and conditions outlined above.

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## **Insurance Consent and Disclaimer Form**

**Purpose:** This form is designed to inform you of the policies and procedures regarding the disclosure of your personal and health information to insurance companies for billing purposes. By signing this form, you consent to the terms outlined below and acknowledge your understanding of your insurance coverage.

### **1. Consent to Disclose Information:**

I, the undersigned, hereby consent to the disclosure of my personal and health information to insurance companies and other entities as necessary for the purpose of billing and processing claims related to services provided by Teatime With Khi, PLLC. This disclosure may include, but is not limited to, information such as diagnostic codes, treatment plans, session notes, and other relevant details required for the proper processing of insurance claims.

### **2. Understanding Insurance Coverage:**

I understand that it is my responsibility to verify and understand my insurance coverage before seeking services from Teatime With Khi, PLLC. This includes checking the extent of benefits, coverage limitations, co-payments, deductibles, and any other financial obligations that may be required by my insurance policy. I acknowledge that Teatime With Khi, PLLC will assist with billing procedures but cannot guarantee insurance coverage or payment.

### **3. Financial Responsibility:**

I am aware that I am ultimately responsible for any fees not covered by my insurance plan. This includes, but is not limited to, co-payments, deductibles, and charges for services that are not covered by my insurance policy. I agree to pay any outstanding balance that remains after insurance payment in accordance with the billing policies of Teatime With Khi, PLLC.



## **Insurance Consent and Disclaimer Form**

### **4. Authorization to Bill Insurance:**

By signing this form, I authorize Teatime With Khi, PLLC to submit claims to my insurance company on my behalf and to receive payment directly from the insurance company. I also authorize my insurance company to release any information necessary to process these claims.

### **5. Acknowledgement and Agreement:**

I acknowledge that I have read and understood this Insurance Consent and Disclaimer Form. I agree to the terms outlined above and consent to the disclosure of my information as described.

### **Client Information:**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for choosing Teatime With Khi, PLLC. We look forward to providing you with quality care and support.



### **Insurance Form**

Thank you for choosing Teatime With Khi, PLLC for your mental health services. Please complete the following form to provide us with your insurance information or indicate your preference for self-pay. By submitting this information, you authorize Teatime With Khi, PLLC to bill your insurance carrier for services provided.

**Insurance Carrier:** \_\_\_\_\_

**Insurance Carrier Phone Number (for claims):** \_\_\_\_\_

**Policy Holder's Name (if different from client):** \_\_\_\_\_

**Policy Holder's Date of Birth:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_

**Relationship to Policy Holder:** \_\_\_\_\_

By providing my insurance information, I authorize Teatime With Khi, PLLC to bill my insurance company directly for services rendered. If using insurance, I authorize Teatime With Khi, PLLC to release necessary medical information to my insurance carrier for the purposes of processing claims. I understand that I am responsible for any co-payments, deductibles, or balances not covered by my insurance. I also understand that I am responsible for verifying the coverage and benefits with my insurance provider and that I may be responsible for the full cost of services if my insurance does not cover them.

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## **Insurance Form**

### ***Self-Pay Option***

Please complete this section if you prefer to pay out of pocket for your sessions.

I choose to self-pay and understand that I will be responsible for the full cost of services at the time they are provided.

**[ ] Yes, I will self-pay.**

I understand that I am responsible for paying the cost of my sessions based on my selected payment option (self-pay).

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Thank you for providing this information. If you have any questions or concerns about your payment options, please don't hesitate to reach out.

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### **Credit Card Authorization and Policy**

**1. Use of Third-Party Services:** Teatime With Khi, PLLC utilizes third-party companies, such as Simple Practice, Headway, Alma, and/or Grow Therapy, for credentialing and billing purposes. These services help us manage administrative tasks related to your care, including appointment scheduling and processing payments. By providing your credit card information, you consent to its use for these purposes.

**2. Credit Card on File:** By signing this form, you authorize Teatime With Khi, PLLC to keep your credit card information securely on file for the purpose of billing. It is your responsibility to ensure that the credit card provided is valid and has not expired. You agree to notify us of any changes to your card information.

**3. Cancellation Policy:** To avoid charges, you must cancel your appointment at least 24 hours in advance. If you do not cancel your appointment with at least 24 hours' notice, or if you fail to attend your scheduled appointment (a "no-show"), a fee of \$150 will be charged to your credit card for a "no-show."

**4. Security and Confidentiality:** Your credit card information will be securely stored and handled in compliance with all applicable privacy and security regulations. It will only be used for the purposes outlined above.

**5. Acknowledgment and Consent:** By signing below, you acknowledge that you have read, understood, and agree to the terms of this Credit Card Authorization Form. You consent to the use of your credit card for the purposes described and understand the cancellation policy.



### **Credit Card Authorization and Policy**

**Client Signature:**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Please Note:**

- Your credit card information will be stored securely and used only for the purposes outlined in this form.
- If you have any questions or concerns about this authorization or our billing policies, please contact our office at 910-939-1110 or [khiana@teatime2.com](mailto:khiana@teatime2.com).

Thank you for your cooperation and for choosing Teatime With Khi, PLLC. We look forward to supporting your mental health and well-being.