

**JAMES M. BARRY MSW, LCSW  
2018 FT. BRAGG RD. , SUITE 114A  
FAYETTEVILLE, NC 28303**

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CLIENT NAME: \_\_\_\_\_  
(LAST) (FIRST) (M.I.)

ADDRESS: \_\_\_\_\_  
(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 sealing medical records away in cabinets and refusing to reveal your information. Today, state and federal laws attempt to ensure the confidentiality of this 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, fill a prescription or send a claim to a health plan, your physician, 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 Date

\_\_\_\_\_  
Guardian (if client is a minor) Date

**CONSENT TO RELEASE INFORMATION FORM**  
**JAMES M. BARRY MSW, LCSW**

Authorization to Disclose Information

I, \_\_\_\_\_, hereby authorize James M.  
Name and sponsor social security number of person giving consent

Barry to release to \_\_\_\_\_ information related to my  
Name of party to whom information is to be disclosed  
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

\_\_\_\_\_  
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 e-mail, 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 it's 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 released information you may desire to keep private.

Furthermore, there is the risk of being overhead by anyone near you if you do not place yourself in a private area and 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

