(Minor) CHART #: _____ THERAPIST INITIALS: _____

Reset

PRINT CLIENT NAME: _____ **DATE:** _____
FIRST MIDDLE LAST

Nickname: _____ Date of Birth ____ / ____ / _____ Age: _____

Address: _____ City: _____ Zip Code: _____

Gender: _____ Ethnicity: _____

School Name: _____ Grade: _____

How did you hear about us: ☐ PCP ☐ Friend ☐ One-Eighty Website ☐ Other: _____

Parent/Legal Guardian 1:

Name: _____ Employer: _____

Relationship: ☐ Mother ☐ Father ☐ Step-Parent ☐ Guardian ☐ Other: _____

Date of Birth: _____ / _____ /_____ Responsible for Billing: ☐ Yes ☐ No

Address (if different) _____ City _____ Zip Code _____

Phones: Mobile (_____) _____ _____ Home (_____) _____ _____ Work (_____) _____ _____

Email: _____ Use for appointment reminder? ☐ Yes ☐ No

Parent/Legal Guardian 2:

Name: _____ Employer: _____

Relationship: ☐ Mother ☐ Father ☐ Step-Parent ☐ Guardian ☐ Other: _____

Date of Birth: _____ /_____/ _____ Responsible for Billing: ☐ Yes ☐ No

Address (if different) _____ City _____ Zip Code _____

Phones: Mobile (_____) _____ _____ Home (_____) _____ _____ Work (_____) _____ _____

Email: _____ Use for appointment reminder? ☐ Yes ☐ No

EMERGENCY CONTACT IF EITHER PARENT/LEGAL GUARDIAN CANNOT BE REACHED:

Name: _____ Relationship to Client: _____

Phones: Mobile (_____) _____ _____ Home (_____) _____ _____ Work (_____) _____ _____

Primary Care Physician (PCP):

PCP Name: _____ Company/Group Name: _____

City: _____ Phone: (_____) _____ _____ Fax: (_____) _____ _____

Authorization to Release Information to PCP: ☐ I Agree ☐ I Decline ☐ None - N/A

HOUSEHOLD MEMBERS (other than self):

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Have any immediate family members deceased? ☐ Yes ☐ No If yes, who? _____

Health Inventory

Please select any area of concern for client:

Alcohol or Drug Use ☐
Alcohol or Drug use in family ☐
Anger/Irritability ☐
Anxiety ☐
Childhood Abuse or Neglect ☐
Depression ☐
Difficulty Making Decisions ☐
Domestic Violence ☐
Excessive Worry ☐
Finances ☐
Gambling ☐
Feelings of Guilt ☐
Grief/Loss ☐
Impaired Memory ☐
Less Interest or Pleasure in Things ☐
Mood Changes ☐
Muscle Tension ☐
Menopause ☐
Nervousness ☐
Pain ☐
Panic ☐
Poor Concentration ☐
Stress ☐
Sexual Problems ☐
Self Esteem ☐
Sexual Assault/Rape ☐
Sleeping Problems ☐
Thoughts of Suicide/Death ☐
Thoughts of Homicide ☐
Weight Loss/Gain ☐

Has the client ever abused alcohol or drugs? ☐ Yes ☐ No Have the parents? ☐ Yes ☐ No
If yes, please explain: _____

Does the client or does any family member suffer from alcoholism, addiction or mental disorders?
☐ Yes ☐ No
If yes, please explain: _____

Has the client ever experienced or witnessed a traumatic event(s)? ☐ Yes ☐ No
If yes, please explain:

_____

_____

_____

_____

_____

_____

Health History

Please select if the client has ever been treated for any of the following:

Allergies ☐
Asthma ☐
Arthritis ☐
Back Pain ☐
Headaches ☐
Hearing Problem ☐
Diabetes ☐
Emotional Disorder ☐
Seizure Disorder ☐
Stomach Problem ☐
Pain ☐
Skin Problem ☐
High Blood Pressure ☐
HIV/Aids ☐
Low Blood Sugar ☐
Cancer ☐
Head/Brain Injury ☐
Heart Disease ☐

Please list any known health issues or disabilities:

_____

Is the client currently under the care of a physician or psychiatrist for any physical or emotional condition?
☐ Yes ☐ No If yes, please provide physician name: _____ and the reason for seeking treatment: _____.

Prior Counseling Information:

Name of Clinician	Year and Length of Treatment

Please list all current medications: _____

_____

Previous hospitalizations (date/reason): _____

Is the client currently involved in any litigation? ☐ Yes ☐ No

If yes, please explain:

_____

Personal History

Reason client is seeking counseling? _____

_____

How would you rate the seriousness of the client's current condition?

0	1	2	3	4	5	6	7	8	9	10
Not Very		Slight			Moderate			Serious		Extremely

What specific behaviors, actions, feelings, or habits would the client like to change about themselves?

_____

_____

What are some of the client's special talents or skills that they feel proud of?

_____

_____

Please describe the client's social functioning/social life.

_____

_____

What are the client's goals for counseling?

_____

_____

Additional Notes:

By signing, I agree the above information is true, to the best of my knowledge.

_____ _____

***CLIENT/GUARDIAN'S SIGNATURE** **DATE**

HIPAA Authorization Form

PLEASE COMPLETE IF YOU WISH TO SHARE ANY CLIENT INFORMATION

OR

DECLINE AT BOTTOM OF PAGE

AUTHORIZE:

One-Eighty Counseling, P.A. has taken measures to protect all of our clients' private health information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices. HIPAA (Health Insurance Privacy & Accountability Act) does not allow us to release any information to outside entities on your behalf without your written consent.

I **am authorizing** the person(s) listed below to obtain protected health information regarding _____.
Client's Name

I understand that One-Eighty Counseling, P.A. is not responsible for the information provided as long as it is given to the person/people that I have listed below. I understand that I may revoke this authorization in writing at any time.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

1. Name: _____ Date of Birth: _____ Relationship: _____

2. Name: _____ Date of Birth: _____ Relationship: _____

3. Name: _____ Date of Birth: _____ Relationship: _____

4. Name: _____ Date of Birth: _____ Relationship: _____

OR

DECLINE:

☐ I **do not** authorize One-Eighty Counseling, P.A. to release any of my protected health information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

_____ _____

***CLIENT/GUARDIAN'S SIGNATURE** **DATE**

INSURANCE / PAYER INFORMATION FORM

CLIENT NAME: _____ DOB: ____ /____ /_____

(FIRST) (MIDDLE) (LAST)

IS THIS CLIENT COVERED BY INSURANCE? ☐ Yes ☐ No

- IS ONE-EIGHTY COUNSELING IN NETWORK WITH YOUR INSURANCE? ☐ Yes ☐ No

INSURANCE COMPANY NAME: _____

(For your Mental Health/Behavioral Health/SA Coverage)

MEMBER ID #: _____ GROUP #: _____

PRIMARY SUBSCRIBER NAME: _____ DOB: ____ /____ /_____

(FIRST) (MIDDLE) (LAST)

ADDRESS: _____ _____ _____

(STREET) (CITY) (STATE) (ZIP CODE)

SSN: _____ _____ _____ PRIMARY PHONE #: (_____) _____ _____

EMPLOYER NAME: _____ RELATIONSHIP TO CLIENT: _____

(SPOUSE, PARENT, etc.)

OTHER INSURANCE: _____

EAP: GROUP: _____ AUTH #: _____ # OF SESSIONS: _____

***IMPORTANT**: PLEASE PROVIDE THE PRIMARY INSURANCE INFORMATION ABOVE (AND A COPY OF INSURANCE CARD) FOR SERVICES RENDERED AFTER THE EAP SESSIONS ARE COMPLETE. NOTE: EAP CERTIFICATION FORMS MUST BE RECEIVED IN OUR OFFICE BEFORE SERVICES ARE RENDERED IN ORDER TO BE BILLED. OTHERWISE, THE PRIVATE INSURANCE WILL BE BILLED.

Welcome! We are honored you chose One-Eighty Counseling to help you with your personal concerns. We respect the notion that reaching out to a therapist can be intimidating and sometimes scary. We want you to know that our professional providers see it as their life mission to help others. Each therapist seeks to meet their client where they are and walk with that individual through any difficulty. With compassion and the highest level of respect and dignity, we will help you on your journey to your very best you. We believe that we have one life to live and we want to help you live your life to the fullest!

Informed Consent for Treatment of Psychotherapy and Office Policies

INTAKE: The first appointment, which is considered an "intake appointment," is a time for you to discuss your concerns, background, and social/developmental history, as well as the problem from your point of view. It is also a time to discuss with the clinician a plan for therapy. When children are in therapy, the child's parent(s) or guardian(s) are involved in the treatment and their participation is expected; however, parents may decide to come to the first appointment without the child, especially if the child is very young, so that the parents may share their concerns candidly without the child present.

TREATMENT TERMINATION: Your participation in therapy is voluntary and therefore can be ended at any time. Our general practice is to have a "termination" session which allows closure to the therapeutic process. It is not helpful to end therapy by no-showing or cancelling sessions. It is important that you discuss with your therapist when you are feeling that you would like to end therapy. We recognize that the therapeutic relationship (the relationship between you and your therapist) is a critical part of success in therapy. If you feel at any time that you and your therapist are not a good fit, please allow us to assist you in referrals to another provider. If, after the intake, your therapist identifies your treatment needs are out of their scope of practice, we will refer you to an appropriate provider. If you no-show or cancel 3 appointments in a row or if you have not been seen in 90 days, your file will be closed.

PROFESSIONAL RECORDS: The laws and standards of our profession require that we keep treatment records. These records are securely kept and maintained in an Electronic Health Records system. We keep brief therapy notes, documenting your attendance, what was discussed in session, your progress towards goals and any homework. You are entitled to receive a copy of your records, or we can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them with your therapist so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

PROFESSIONAL BOUNDARIES: We have an ethical responsibility to refrain from personal relationships with clients that would create a conflict of interest. Therefore, if your therapist comes into contact with you in a public setting, your therapist will not engage in a conversation with you in an effort to protect your confidentiality. Additionally, your therapist and One-Eighty Counseling, will not accept friend requests, follows or other forms of interaction on any personal social media outlet. If you choose to follow or "like" any of One-Eighty Counseling's business social media pages, you acknowledge that this may pose a risk to your confidentiality (ie: others will see that you followed this page).

LITIGATION LIMITATIONS: If you become involved in a divorce or custody dispute, you are agreeing that we will not provide evaluations or testimony in court, as we are not trained to make custody recommendations, and this creates a dual-relationship. Due to the nature of the therapeutic process, you understand that should you become involved in legal proceedings, there is a potential risk that the therapeutic relationship/alliance could be jeopardized. We find it best practice for therapists to not be involved with legal proceedings, which include court testimony and disclosure of therapy records.

CONTACTING YOUR THERAPIST: If you need to reach your therapist, please call our main line at (919) 772-1990, select the appropriate extension and leave a detailed message. Your therapist will try to return your phone call within 24 hours. Our administrative staff checks our general office voicemail messages frequently, but NOT on the weekends or times that the office is closed (ie: holidays, evenings). Messages left on our general voicemail after hours will be returned the next business day.

EMERGENCIES: Due to the nature of our work, therapists are not always immediately available to address emergency concerns. If you are at risk of harm to yourself or someone else, please call 911, go to your nearest hospital emergency room, or call Holly Hill Hospital at 800-447-1800.

ELECTRONIC COMMUNICATION POLICY: Due to the confidential nature of therapy, we limit the use of correspondence via electronic methods (ie: email, text, etc.). The times where we will use email or text messaging to communicate with you include: appointment reminders, cancellations or rescheduling, providing a list of resources or providing homework. All other use of email/text is discouraged. If you do not want to be contacted via email/text please document this in writing on your intake form. DO NOT use email/text for an emergency. Additionally, email is not to be used in lieu of or as therapy. If you email us or respond to an email using your personal email account, or unsecured email account (Gmail, Yahoo, etc.) you are acknowledging that this is an unsecure means of communication and will not hold One-Eighty Counseling liable if the information you shared in the email is breached.

CONFIDENTIALITY: Information disclosed in therapy sessions and in your therapy records is confidential and may not be released without your written permission, except where required by law. The following are conditions where confidentiality may be broken.

Mandatory disclosure required by law:

- There is a reasonable suspicion of **the child abuse or neglect or elder (age 65 or older) abuse or neglect or a vulnerable adult.** A report will be made to appropriate protective agencies.
- When you **present/threaten grave bodily harm to others or to property**. We have a legal duty to warn those threatened, and to contact law enforcement.
- When you are **actively suicidal or threaten significant bodily harm to yourself**. We have a duty to obtain help from others such to do what is necessary to keep you safe.
- Disclosure may be required pursuant to **legal proceedings**. If your therapy records are COURT ORDERED we are required by law to disclose them.
- If you are on **probation/parole**, it may be legally required that we share information with various individuals appointed by the courts.
- If you are serving in **active duty in the military** and you disclose information that the therapist believes would **impact your fitness for duty or deployment**, we may be required to report this to your chain of command.

MINORS & PARENTS: In the state of North Carolina, children less than 18 years of age cannot independently consent to or receive mental health treatment without parental consent. While privacy in psychotherapy is very important, particularly with adolescents, parental involvement is also essential to successful treatment, and this may require that some private information be shared with parents or guardians.

Children & Treatment Consent: To provide consent for treatment for a child you must either have sole legal custody OR shared legal custody OR legal guardianship. If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, our services fall under this, and you may be in violation of a court order if you fail to inform the other parent of our services with your child. By signing this form you are stating that you have the legal right to consent for this child.

COUPLES/FAMILIES: The therapist is treating the couple or family unit, and in such the confidentiality lies within the couple or the family unit. Information will not be released without the consent of ALL members of the family or couple in treatment. Additionally, there may be times where the therapist sees members of the family or couple individually. The therapists will use their clinical judgment when revealing information shared during an individual session to the couple or family. Therapists maintain a "no secrets policy" and if a "secret" is revealed during an individual session that could hurt the therapeutic relationship or jeopardize the therapy and the individual refuses to disclose, therapy may be terminated. The therapist will work with you on ways to disclose the information to the others.

INSURANCE:

1. It is your responsibility to contact your insurance company to verify eligibility, benefits, and reimbursement policies specific to your health insurance policy.
2. Your therapist's fees are generally considered to fall within the acceptable range by most insurance companies, called "Usual, Customary, and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area, while others reimburse based on an established contractual rate.
3. Insurance contracts do not necessarily provide coverage for all services or for all types of providers. Some insurance companies arbitrarily disallow coverage for certain services and types of providers.
4. Your insurance company will require that your therapist include on any billing statement of services a Procedural Code(s) called a CPT code and a Primary Diagnostic Code, or ICD Code. You may discuss the use of these codes, but all final diagnostic decisions must be left to your therapist's discretion.
5. Your therapist can discuss the diagnosis to be submitted to your insurance company with you, upon your request.
6. By submitting your insurance information to One-Eighty Counseling and requesting that we bill your insurance company on your behalf, you are giving this practice the following "signature on file" permissions: permission to release private information necessary to process the insurance claim on your behalf and permission for your insurance company to reimburse this provider directly.

Payment in full is expected at the time of service. This includes your portion of the fee not covered by your policy, including any co-payments or co-insurance, and if applicable, meeting your required annual deductible. You will also be responsible for any portion of the balance due that is denied by the insurance company, regardless of the circumstances.

Billing Practices and Financial Agreement Form

Client Name: _____ Client DOB: _____

PAYMENT AND FEES:

	MASTERS	PhD
Intake session:	$175	$225
60 minute session:	$135	$175

- If you are utilizing your health insurance for mental health benefits your co-pay, coinsurance or deductible amount will be due at the beginning of each session **in addition to** any outstanding balances.
- Additional services will be billed at clinician's hourly rate. Such additional services may include, but are not limited to: consultation with other professionals, preparation of reports or correspondence with other professionals or service providers, and phone calls lasting over 10 minutes. Phone sessions will be documented as such and are not reimbursed by insurance. If additional services are provided and are not an hour in length, the rate will be pro-rated.
- Acceptable forms of payment are cash, check, or debit/credit card and flexible spending cards. *If your check is deposited and returned for insufficient funds, you will be charged a $25.00 Insufficient Funds Fee.* Please notify your therapist if any problem arises during the course of therapy regarding your ability to make timely payments.
- If your account becomes late over 90 days, One-Eighty Counseling may send it to collections and you will incur additional charges associated with collections, including costs and reasonable attorney's fees.
- *We reserve the right to temporarily suspend scheduling further appointments if an outstanding balance is not paid and/or payment arrangements are not made and complied with*. Referrals to appropriate services will be made as requested to ensure continuity of care in these cases.
- If a clinician is required for court, a fee of $250.00 per hour (with a 1-hour minimum charge) and automatic 1-hour prep session fee is payable prior to the court date ($500.00 retainer deposit). This includes the clinician's physical presence and/or standby phone testimony.

CANCELLATION AND LATE ARRIVAL:

- Since your appointments involve the reservation of time specifically for you, a minimum of 48 hour notice is required for rescheduling or cancelling an appointment. If a 48 hour notice is not provided, you will be charged a $50.00 missed appointment fee.
- If you no-show or cancel 3 sessions in a row, termination of therapy may result. If this happens we will refer you to another therapist.
- If are going to be MORE than 15 minutes late to your scheduled session, please notify us as soon as possible. If your therapist is unable to accommodate the late arrival, you will need to reschedule and this may result in a $50.00 no-show/late cancellation fee.
- Please note, insurance companies will not reimburse for missed sessions or sessions that are cancelled late, and you will be responsible for the $50.00 no-show/late cancellation appointment fee to be paid prior to being seen at your next scheduled appointment time.

Please complete the following information:

☐ **In Network Insurance**

I have insurance 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.

Billing Practices and Financial Agreement Form, Cont.

☐ **Out of Network Insurance**

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 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 agree to a pay the full session amount per session and understand that my insurance company may or may not reimburse me for a portion or all of the full rate.

☐ **No Insurance**

I have no insurance, or I request that no insurance claims be filed by this office. I will accept full financial responsibility for any services the office provides and agree to sign necessary waivers provided to me by One-Eighty Counseling.

Credit Card Authorization

One-Eighty Counseling offers a secure and HIPAA compliant way of storing your credit/debit card information on file. Our practice management software, TherapyNotes, uses enhanced security called TransArmor to store sensitive credit card data. We never store credit card account numbers, instead representing each credit card with only a security token. This allows One-Eighty Counseling to maintain credit card information on file for future use without actually having knowledge of or access to the credit card numbers.

With your permission, One-Eighty Counseling can conveniently charge your card for fees associated with services rendered at our practice. These fees include, but are not limited to:

- Co-pays or co-insurance amounts required by your insurance policy.
- Insurance deductible amounts.
- Missed appointment fees.
- Non-covered services by your insurance.

Please be assured that your credit/debit card will never be charged without your prior approval and is only stored as a matter or convenience to our clients.

I consent to having my credit/debit card stored securely on file**. Please initial:** _____

Please let our front office staff know if you DO NOT wish to have your credit/debit card placed on file.

My signature below indicates that I have read, understood and have had any questions answered to my satisfaction concerning the billing practices of One-Eighty Counseling, P.A. I hereby agree to the financial agreement and accept financial responsibility for services provided to me by One-Eighty Counseling, P.A. in accordance with this policy.

Client/Guardian/Responsible Person Signature:_____ Date: _____

One-Eighty Counseling Staff Signature: _____ Date: _____

Consent for Treatment

I have read The Informed Consent for Psychotherapy Treatment and Office Policies and I understand and accept the policies contained therein. Having read that information, I hereby agree to assessment and treatment. I acknowledge that this consent is truly voluntary and is valid until revoked. I understand that I may revoke this consent at any time and that my involvement in therapy is completely voluntary.
I, or as the legal guardian of _____, do hereby seek and consent to take part in psychotherapy services provided by One-Eighty Counseling, PA. I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

Initials: _____

Financial Release

I further understand that One-Eighty Counseling, P.A. may use confidential information to bill and be paid for services. I hereby consent for One-Eighty Counseling, P.A. to release information to the billing agent/funding source and for the billing agent/funding source to release information to One-Eighty Counseling, P.A. for this purpose.
I understand that I am responsible for any fee not covered by insurance and agree to pay for sessions or co-pays at time of service. I also understand the cancellation policy and that I will be responsible for the late cancellation and/or no-show fee if I do not provide a 48-hour notice.

Initials: _____

Electronic Communications Policy

I acknowledge that I have read and understand the policy regarding communication with (both to/from) One-Eighty Counseling, P.A., and/or my individual therapist via electronic methods

Initials: _____

Insurance Release

I hereby authorize One-Eighty Counseling, P.A. to submit claims for mental health services. I authorize the release of any information relating to all claims and benefits submitted on my behalf or on behalf of my child or minor in my legal custody. I further acknowledge that my signature here authorizes the clinician or his/her billing specialist to submit claims for services rendered without obtaining my signature on every claim. I understand that I am responsible for paying the co-pay, coinsurance or deductible amount at the time of service. If the claim is denied, I agree to pay for the service. I authorize payment of medical benefits for assessment or psychotherapy to the providing clinician, for services rendered.

Initials: _____

HIPAA Notice of Privacy Practices

I acknowledge that I have been given the opportunity to read a copy of the Notice of Privacy Practices for One-Eighty Counseling, P.A. Additionally, copies are available to me in the waiting room or from my therapist (by request).

Initials: _____

Signatures

My signature below indicates that I have read, understood, and been offered a copy of the document, *Informed Consent for Treatment of Psychotherapy and Office Policy*, and any other document(s) mentioned above. I am acknowledging that I agree with the information presented within, and by initialing the statements above, agree to each item as indicated.

Print Name:_____ Sign Name:_____ Date: _____

Print Name:_____ Sign Name:_____ Date: _____