WELCOME *Please provide us with the following information*

DATE ____________ TIME ____________ REFERRAL SOURCE ____________

NAME ____________ DOB____________ AGE ____________

MARITAL STATUS ____________ SEX ____________ RACE ____________

ADDRESS ____________

HOME PHONE ____________ WORK PHONE ____________ CELL ____________

MAY A VOICE MESSAGE BE LEFT AT ANY OF THE ABOVE NUMBERS? ____ SPECIFY WHICH ____

EMERGENCY CONTACT ____________ PHONE ____________

CURRENT EMPLOYER OR SCHOOL ____________

WHAT PROBLEM(S) BROUGHT YOU IN TODAY? ____________

PLEASE RATE THE SEVERITY OF YOU PROBLEMS BY CIRCLING A NUMBER ON THE FOLLOWING SCALE:

0 1 2 3 4 5 6 7 8 9 10

No Discomfort — Moderate Discomfort — Extreme Discomfort

LIST HISTORY OF MEDICAL CONDITIONS/ILLNESSES/SURGERIES

____________ ____________ ____________

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING VITAMIN/MINERAL SUPPLEMENTS:

____

____

PLEASE LIST ALL CURRENT ALLERGIES, INCLUDING FOOD ALLERGIES:

____

____

PRIMARY PHSCIAN: ____________
(Your physician will not be contacted without your consent)

DATE OF LAST PHYSICIAN EXAMINATION: ____________

NUMBER OF PERSONS LIVING IN YOUR CURRENT HOUSEHOLD: ____________

NUMBER OF CHILDREN: ____________ AGE(S) OF YOUR CHILDREN: ____________

WOULD YOU DESCRIBE YOUR CURRENT MARITAL/SIGNIFICANT RELATIONSHIP AS (circle one):

Poor Fair Good Very Good Excellent

ARE YOU CURRENTLY EXPERIENCING FINANCIAL DISTRESS: NO YES

ARE YOU EXPERIENCING LEGAL PROBLEMS? If yes, please explain ____________________

____

EDUCATION COMPLETED____________________ DEGREE ____________________

HAVE YOU EXPERIENCED ANY ABUSE? NO YES (indicate type(s) below)

_______Sexual _______Neglect _______Verbal

_______Physical _______Spiritual _______Emotional

PLEASE CHECK ALL OF THE BELOW THAT YOU CURRENTLY USE AND INDICATE QUANTITY:

- Cigarettes/tobacco ____________________
- Alcohol ____________________
- Coffee ____________________
- Marijuana ____________________
- Cocaine ____________________
- Other drugs ____________________

DOES ANYONE IN YOUR CURRENT HOUSEHOLD, OR IN YOUR FAMILY OF ORIGIN, HAVE ALCOHOLISM OR OTHER SUBSTANCE ABUSE PROBLEMS? NO YES (Please explain below)

____

HAVE YOU EVER PREVIOUSLY RECEIEVED COUNSELING/MENTAL HEALTH SERVICES? NO YES

Problem addressed____

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC TREATMENT? NO YES
If "yes," please list dates/hospitals where treatment was provided: ____________________

____

HAVE YOU EVER ATTEMPTED SUICIDE? NO YES
If "yes," please list number of times, when, and method: ____________________

____

ARE YOU CURRENTLY EXPERIENCING ANY THOUGHTS OF SUICIDE? NO YES
If "yes," do you have a plan? Please describe: ____________________

____

ARE YOU CURRENTLY EXPERIENCING ANY THOUGHTS OF HARMING SOMEONE ELSE? NO YES
If "yes," do you have a plan? Please describe: ____________________

____

DOES ANYONE IN YOU FAMILY HAVE A HISTORY OF MENTAL ILLNESS? NO YES
If "yes," can you please provide brief details? ____________________

CONSENT FOR SERVICES:

By signing below, I consent to receive evaluation, diagnostic and treatment services. Should I decide to enter into treatment/counseling; a personalized treatment plan will be designed for me, with my input. This treatment plan will be subject to my approval and will be authorized by my signature. I understand that this is voluntary treatment, and that I have the right to withdrawal from treatment at any time.

Client Signature ___________________________ Date ________________________

Clinician Signature _________________________ Date ________________________

NOTICE OF PRIVACY PRACTICES

A "Notice of Privacy Practices" that describes how your private health information is handled by this office has been provided with your intake packet.
(Please take a moment to review this and note any questions that you may wish to discuss. Please check one of the following boxes to verify your receipt (or non-receipt) of the "Notice of Privacy Practices." Thank you.)

☐ Yes, I have been given a "Notice of Privacy Practices" that informs me as to how my private health Information is handled and communicated by this practice, and also provides me with information regarding filing a complaint should I feel that my private health information has been used incorrectly.

☐ No, I have not been given a "Notice of Privacy Practices."

____ ______________________________

Client Signature Date

HOW MAY WE CONTACT YOU?

Occasionally there may be a need to leave a phone message regarding your appointment time, returning your phone message, or other issues related to your treatment. Please indicate your preferences below and provide your signature to indicate consent.

I may be contacted and a message may be left at the following phone number(s):

____

I authorize that messages may be left with the following person(s):

____

☐ I do not want ANY messages left by phone or with any person.

____ ______________________________

Client Signature Date

Appointment and Cancellation Policy for Appointments

Our goal is to provide quality care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our clients in need of care.

Scheduled Appointments

For a schedules appointment please call (910) 686.3505.

Cancellation of an Appointment

Please be courteous and call the above number promptly if you are unable to attend an appointment. Except in the case of emergency, twenty-four (business hours) advanced notice is required and will allow this time to be reallocated to someone in urgent need of treatment. This is how we can best serve the needs of our clients.

We reserve the right to bill for an appointment not cancelled within the twenty-four hour time frame at the rate of $35 per appointment.

How to Cancel Your Appointment

To cancel appointments please call (910) 686.3505. If you do not reach someone, you may leave a detailed message on voice mail. You may not cancel via email.

No Show Policy

A "no show" is someone who misses an appointment without canceling it in advance. A "no show" is considered not arriving to an appointment within 15 minutes of the scheduled appointment time. No-shows inconvenience those individuals who need quick access to an appointment and are on a waiting list.

A failure to present at the time of a scheduled appointment will be recorded in the clients' chart as a "no-show". Three consecutive "no-shows" will result in termination of care and referral to another service provider.

We reserve the right to bill for a "no-show" at the rate of $35 per missed appointment.

Phone Message Policy

We will make every effort to return your phone messages as soon as possible within the same day, however, if it involves a life threatening emergency – i.e. suicidal/homicidal ideations individuals will need to call 911 or go to the nearest hospital.

<u>We are happy to receive your calls to schedule services and to be available for crisis situations. Discussions regarding non-emergency treatment issues should be reserved for the counseling session.</u>

Fees and Medical Records

Payment in full is due at the time of the visit if you do not have insurance coverage. We require any co-pay, deductible or coinsurance to be paid on the same day services are rendered.

Porters Neck Counseling will charge a reasonable fee to cover the administrative costs incurred in searching, handling, copying, and mailing of medical records to the patient or the patient's designated representative. Inclusive of searching, handling, copying, and mailing costs:
Administrative fee of $25.00 then:
$.75 for first 25 pages
$.50 for pages 26-100
$.25 for pages over 100

Should documentation be needed outside of a court proceeding – i.e. treatment summary and/or recommendation letter to a third party provider a $50 fee will be assessed.

Should you require testimony or report in a civil, criminal or any other legal matter, that fee shall be $500.00 per hour, **due in advance.** This charge will be for all services including, but not limited to: attorney consultation, document review, court testimony, wait-time in court, case correspondence, travel time and all other services relating to this activity. Should testimony or a report be needed, payment of the equivalent of a one-day retainer ($1500.00), **due in advance** will be required. Should a scheduled trial appearance be cancelled or postponed with less than seventy-two hours' notice the retainer will be non-refundable. For additional information on our legal participation policy, please consult the office manager.

PLEASE SIGN BELOW TO CONFIRM THAT YOU HAVE READ AND UNDERSTAND THE ABOVE POLICIES. PLEASE DISCUSS ANY QUESTIONS OR CONCERNS WITH YOUR THERAPIST. THANK YOU.

____________________________ ____________________________

SIGNATURE DATE

Insurance Information

PRIMARY INSURANCE: ___________________________

SECONDARY INSURANCE: _________________________

CLIENTS NAME:__________________ BIRTHDATE: _________________

SOCIAL SECURITY: ____

MARITAL STATUS:__________ EMPLOYER: ______________________

ADDRESS: ____

CITY/STATE:_________________________________ZIP: ______________

INSURANCE ID:_____________________________ GROUP/POLICY: ________

HOME PHONE: _________________ OTHER PHONE: ____________________

PATIENTS RELATIONSHIP TO INSURED:____

INSURED NAME (if different than patient)___________________ **SSN:** ______________

SEX: M / F **Date of Birth: ____ /____ /_____ PHONE:__________________**

INSURED ADDRESS:____

CITY/STATE:____________________________________ ZIP:___________________

PLEASE PROVIDE INSURANCE CARD SO THAT WE MAY COPY FOR OR RECORDS

I give this office permission to release any information obtained during evaluations or treatment of this client necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I understand that I am responsible for all charges, regardless of insurance coverage.

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the provider who provided service. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

______________________________________ ______________________

Client's (or parent/guardian's) Signature **Date**

CURRENT SYMPTOMS/PROBLEMS (CHECK ALL THAT APPLY):

Emotional symptoms

__ anger __ depression __ anxiety __ extreme mood shifts

__ irritability __ worry __ frustration __ helplessness

__ Hopelessness __ fear __ apathy __ lack of emotions

__ guilt __ others (specify) ____

Notes (for counselor's use):

Mental symptoms

__ problems with concentration __ inattention __ memory problems

__ difficulty making decisions __ distractibility __ racing thoughts

__ repeated unwanted thoughts __ other (specify) ________________________________

Notes (for counselor's use):

Physical symptoms:

__ increase or decrease in appetite __ sleeps difficulties __ muscle tension

__ tearfulness/crying spells __ increased heart rate/pounding heart __ sweating/chills

__ stomach or intestinal distress __ frequent or severe headaches __ body pain/numbness

__ other (specify): ____

Notes (for counselor's use):

Behavioral symptoms:

__ hyperactivity __ impulsivity __ binge eating/overeating __ suicidal gesture/attempt

__ induced vomiting __ withdrawal __ arguing __ increased alcohol use

__ fighting/aggression __ disorganized __ oppositional/defiant __ self-injury

__ lying/deceitfulness __ avoidance of school or job

__ other (specify) ____

Notes for counselor: