Date:______________________

DEMOGRAPHIC INFORMATION

Please mark only one box clearly

Last Name	First Name	Middle Name	Suffix ☐ none ☐ circle I, II, III, IV ☐ Jr.	Maiden (required)

Address:

Social Security Number

Gender
☐ Male
☐ Female

Date of Birth

County of Residence

____

If applicable, county of Department of Social Services providing Medicaid

____

Please include area code with phone number

Home Phone:

Cell Phone:

Work Phone:

Which do you prefer?
☐ Home ☐ Cell ☐ Work

Emergency Contact//Next of Kin:

NAME:______________________________________

Phone number:________________________________

Relationship to client:__________________________

Is client a minor or have a legal guardian?

☐ Yes ☐ No

Name:_____________ ________

Relationship:________________

Phone number of legal guardian, if applicable:

____

Proficient in English
☐ Yes
☐ No

Secondary Language
☐ N/A
☐ English
☐ French
☐ German
☐ Sign Language
☐ Spanish

Race
☐ American Indian/Native American
☐ Asian
☐ Black
☐ Multiracial
☐ Pacific Islander
☐ White
☐ Other

Ethnicity
☐ Hispanic, Cuban
☐ Hispanic, Other
☐ Hispanic, Mexican
☐ Not Hispanic Origin
☐ Hispanic, Puerto Rico
☐ Unknown

Martial Status
☐ Single (never married)
☐ Married
☐ Divorced
☐ Domestic Partners
☐ Separated
☐ Annulled
☐ Widowed

What is your source of income?
☐ N/A - none
☐ Earned income
☐ Disabled – receiving SSI/SSDI
☐ Disabled – disability request pending (SSI/SSDI)
☐ Other:_______________

What is your Household Size?

What is your ANNUAL income?

Employment
☐ Employed Full Time
☐ Employed Part Time
☐ Unemployed
☐ Disabled
☐ Retired
☐ Student

Living Arrangement
☐ Homeless (street, vehicle, shelter)
Shelter name: ____________
☐ Nursing Home
☐ Independent Rooming Home
☐ Private Residence
☐ Residential Facility
☐ Other:____________

Special Need Accommodations
☐ N/A
☐ Wheelchair / Mobility Needs
☐ Deaf / Hearing Impaired
☐ Intellectual Disability
☐ Childcare
☐ Visually Impaired
☐ Physical Disability
☐ Frail Senior
☐ Foreign Language Interpreter
☐ Other:
____

Education Level: (highest completed)
☐ High School Graduate
☐ GED
☐ Some College
☐ Associate Degree
☐ Baccalaureate Degree
☐ Special Education
☐ Post Graduate Degree
☐ None, never attended school
☐ _____________Grade (i.e. 11th)

Referral Source
☐ Self – no referral
☐ School
☐ Private Physician
☐ State Facilities
☐ Other Health Care
☐ Community Agency
☐ Family / Friends
☐ Other Outpatient
☐ Psychiatric Services/General Hospital
☐ Other
:__________________________

Have you been arrested in the past 30 days?
☐ Yes How many times?______
☐ No

Are you pregnant?
☐ Yes
☐ No
☐ N/A

Veterans Benefits?
☐ **Yes**
☐ **No**

If yes, which war:
____

Who served?
☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Sibling**

DEMOGRAPHIC INFORMATION
(Continued)

Date:____________________

LAST NAME: ________________________________ **FIRST NAME:** ____________________________

Are you currently suicidal? ☐ Yes ☐ No **Are you currently homicidal?** ☐ Yes ☐ No

Briefly explain the symptoms that are you currently experiencing?

____

____

____

What is your desired outcome for this visit?

____

____

____

Are you currently taking any medications: ☐ Yes ☐ No **If yes, please list ALL medications below**

Name of medication	Dose	Frequency Taken

LIST ALL ALLERGIES **None:** ☐

1. ______________________ ☐ **Intolerance** ☐ **Allergy** **3.** ______________________ ☐ **Intolerance** ☐ **Allergy**

2. ______________________ ☐ **Intolerance** ☐ **Allergy** **4.** ______________________ ☐ **Intolerance** ☐ **Allergy**

HEALTH/MEDICAL INSURANCE

☐ None ☐ Medicaid ☐ Medicare ☐ Other Insurance ______________________________

MEMBER ID# :________________________________Effective date: ________________

Primary Care Doctor (Name, address, Phone #, Fax #)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

DHHS DIVISION OF MH/DD/SA
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION
(45.CF.R. Part 160 and 164: 42 C.F.R. Parts 2; G.S. 122 C)

This authorization form implements the requirements for consumer authorization to use and disclose health information.
Protected by the federal privacy laws, 45 C.F.R. parts 160 and 164: the federal drug and alcohol confidentiality law, 42 C.F.R. Part 2; and state confidentiality law governing mental health, developmental disabilities, and substance abuse services, G.S. 122C.

Consumer Name:________________________________

Date of Birth:_________________________

Record Number:______________________________

I, ____, request and authorize LSJ Counseling and Clinical Services
(*Name of Consumer or Legally responsible person/personal representative*)

to release/receive specified information concerning me for use and/or disclose to/from

____
(*Name of agency/facility to whom the requested use or disclosure will be made*) *Address* *Phone number*

The data to be released may include the following protected information:

□ Treatment Plan____ □ Current Medicine_____ □ Diagnosis_____
□ Psychological Testing_____ □ Progress Notes/Reports____ □ Fact of Admission____
□ Psychiatric Evaluation_____ □ Substance Abuse Information □ HIV/AIDS Information_______
□ Intake/Screening Assessment____ □ CCA/Assessments □ Education records
□ Criminal Record □Treatment history summary □Discharge summary
□ Other – Specify_______________________________

Specific Purpose: □ Continuity of Care □ Service Delivery □ Other:_______________________________________

I understand that I may revoke this authorization at any time except that action has been taken in reliance of it (or unless this authorization is give as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy). In any event, if not revoked earlier, this authorization expires automatically:
□ upon satisfaction of the need for disclosure; □ within (1) year from the date signed; □ under the following condition____

Consumer Signature:_________________________________ Date:________________________

Legal Responsible Person/Personal Representative Signature:____

Date:_______________________________________ Please Print Name:__________________________

Please explain Representative's authority to act on behalf of consumer:__________________________________

Consent for Treatment

Consumer Name: _______________________________ Record #: ______________________

Consent for Treatment

• I agree to participate in the treatment program provided by LSJ Counseling and Clinical Services.
• I understand that treatment will consist of the following:

☐Comprehensive Clinical Assessment
☐ Therapy
☐ Individual Therapy
☐ Family Therapy
☐Group Therapy

• I have been informed, in advance, of the alleged benefits, potential risks, and possible alternative methods of treatment.
• I understand in the case of an emergency, I may contact the police (911), seek emergency medical care at the nearest emergency room or call the 24-hour Crisis Line at (704) 930-4341.
• I understand that this consent for service and treatment is valid for one year.
• I understand that should it be determined that I do not need further treatment or that I will not benefit from these services, these services will be terminated and as appropriate, a referral made to another agency.
• I understand and have been informed that this service is voluntary and that this consent may be withdrawn at any time.

I fully understand the above statements that have been read and explained to me by a member of the treatment staff. I also understand that as the Parent/Guardian/Custodian, I may appeal any grievances to the Director and may request a meeting regarding the grievance.

____ _____________________
Person Served Date

____ _____________________
Parent/Guardian Date

9711 David Taylor Drive
Suite 201
Charlotte NC 28262

Financial Policy

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at each appointment. I understand the charge to be $135 for the initial appointment and $125 each subsequent appointment if not covered by insurance. I understand that missed appointments or cancelled appointments where 24 hours notice was not provided will be charged the full fee. I understand that this charge is not covered by insurance and is my responsibility. I understand that I will be charged $50 should my records have to be provided to another party at my request. I understand I will be charged $50 for any letter or report that I request or require to be completed on my behalf. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.

LaKesha Shingler Howell, LCSW, LCASA, CSOTP will honor contractual agreements made with those managed health care companies that stipulate specific reimbursement restrictions.

X ____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by LaKesha Shingler Howell, LCSW, LCASA, CSOTP. I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to end treatment.

X ____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize LaKesha Shingler Howell, LCSW, LCASA, CSOTP to file my insurance claim on my behalf for services rendered, and authorize the release of necessary medical information for insurance reimbursement purposes.

X ____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X ____

CLIENT/GUARDIAN SIGNATURE DATE

9711 David Taylor Drive
Suite 201
Charlotte NC 28262

(704) 910-0136 **lakesha@lsjcounselingandclinical.com**

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name: ____

DOB: _________________________ *SSN:* ______________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of LaKesha Shingler Howell's Privacy Practices.

____
Signature of Client

____
*Signature or Parent, Guardian or Personal Representative**

Date _____________

** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).* _____________

❑ *Client Refuses to Acknowledge Receipt:*

____ __________
LaKesha Shingler Howell, LCSW, LCASA, CSOTP *Date*

LaKesha Shingler Howell

Licensed Clinical Social Worker C012237

LSJ Counseling and Clinical Services, PLLC
9711 David Taylor Drive Suite 201 Charlotte NC 28262
Tel (704) 910-0136 Fax (866) 800-2456

Client Information Form

Instructions: *To assist in getting information from you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.*

Information supplied by: ____________________________

Relationship to client: _____________Is the client a minor (under the age of 18?)Yes No

Name: _________________________________ Birthdate: ____/____/____ Age: ____ Sex: M F

Address: __________________________________ City: _____________________ Zip: __________

Home Phone: ______________________ Cell: ______________________ Work: ________________

Email address: ____

Marital Status: Single Married Divorced Separated Widowed

I was referred to this therapist/counseling center by: ______________________________________

I give/don't give (circle one) consent for LSJ Counseling and Clinical Services to contact the person who referred me to let them know I came for an initial visit.

In case of emergency, contact: ____

Relationship: ________________________Phone: ___________________________________

The Process of Therapy

Participating in therapy can result in a number of benefits, including the improvement of interpersonal relationships and the resolution of the specific concerns that led you to seek therapy. However, working towards these benefits requires effort and intentionality on your part. Psychotherapy requires your very active involvement and efforts to change your thoughts, feelings or behaviors. Your therapist will ask for your feedback and views on your therapy, the efforts and progress we are making, and will expect you to be open about these.

Remembering or talking about unpleasant events, feelings, or thoughts during therapy can result in your experiencing considerable discomfort or strong feelings of anger, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Attempts to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Changes will sometimes be easy and swift, but more often they will be slow and frustrating. Many clients are anxious for such change to occur right away. However, emotions, thoughts, attitudes, habits, and relationship patterns that have developed over years will take some time to change.

During the course of therapy, your therapist is likely to draw on various psychological approaches according to the problem that is being treated. LaKesha's approaches are generally cognitive-behavioral, psychodynamic, (family) systemic, developmental, psycho-educational, and mindfulness-based. Issues related to emotional, physical, spiritual and intellectual well-being are interrelated and may be addressed to work toward wholeness.

If you have any questions about any of the procedures used in the course of your therapy, please bring them up.

Therapy never involves dual relationships (business, sexual, social media, etc.) that would compromise your psychotherapy process. You have the right to terminate therapy at any time. If you choose to do so, LaKesha will offer to provide you with names of other qualified professionals whose services may better suit you.

I have read and understood the process of therapy with LaKesha Shingler Howell.
Initials: ____________

OFFICE POLICIES AND PROCEDURES
CONFIDENTIALITY

The information you share with your therapist is confidential and will not be released without your written consent. The only exceptions to this privilege of confidentiality are situations involving reasonable suspicions of:

1. Incident(s) of abuse of a child, an elderly person, or a dependent adult in the past or present.
2. Danger or threat to harm to oneself or to others.
3. Certain other legal situations, such as court order or a court-ordered evaluation.

North Carolina State law **mandates** the reporting of reasonable suspicion or disclosure of abuse (physical, sexual, emotional abuse and/or neglect) towards a child, an elderly person, and/or a dependent adult. **Mandated reporting** is also required where there is reasonable suspicion that the client presents a danger of violence to others or where the client is likely to harm him/herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

In the case of couples or family therapy, your therapist holds a "**no-secret policy**." Because the "client" in such cases is not the individuals involved, but the couple or family as a unit, information shared in one-on-one contexts may be revealed to the other members of the unit if the therapist deems it important or necessary for the health and benefit of the whole.

I agree to avail myself and/or the above-name child to this therapist's professional services and consent accordingly to the use of individual psychotherapy, group therapy, couples counseling, and/or family therapy.
Initials: ____________

PAYMENT

Payment is made at each therapy session, unless other arrangements have been made with your therapist. Your therapist does not take all insurances and therefore maybe out of network.

Counseling sessions usually last **50 to 55 minutes**. The charges range from **$80-$125 per session**, with possible increases over time. The rate increase, however, will not cause significant difficulty on the client, and will always come out mutual agreement between the client and therapist.

Your therapist accepts payments in cash, check (written to LSJ Counseling and Clinical Services), and credit card. There is a $35 charge for a returned check.

Your appointment time has been especially reserved for you. If you are unable to keep your appointment, **please call at least 24-48 hours in advance** to avoid being charged for the full session. Monday appointments need to be cancelled **72 hours** in advance (i.e., by the previous Friday).

LSJ Counseling and Clinical Services does not have the facilities for child care, so we request that you do not bring children with you unless they are specifically involved in counseling.

I accept responsibility for paying all charges in full. **Initials: ____________**

COMMUNICATIONS

By signing below, you are indicating that you understand the confidentiality of electronic communications (including, but not limited to email), cannot be guaranteed. Electronic communications are inherently vulnerable and insecure and may result in the unintentional harmful disclosure of personal information. For this reason, it is wise to ***limit emailed communications to scheduling or other administrative issues only***.

You may send your therapist via email (lakesha@lsjcounselingandclinical.com) or voicemail (704-930-4341). Your use of email with your therapist implies consent for reciprocal use of electronic communications as well. You will typically receive reply within 48 hours. **In the case of a life-threatening emergency, please call 911 or the 24-hour Suicide and Prevention Hotline at 1-800-273 TALK (8255).**

If the content of an email contains information other than that related to scheduling, please let your therapist know if you would like a response. Otherwise, the content can be addressed during a following appointment.
Please indicate if you agree to receiving email according to these terms by circling **YES** or **NO**.

If yes, email:____.

I understand and agree to these terms.

Name (Printed): ___________________________________

Signed: ___________________________________ Date: ____________________

Therapist Signature: ___________________________ Date: ____________________