LSJ Counseling & Clinical Services

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

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:_____

County of Residence

_____

If applicable, county of Department of Social Services providing Medicaid

_____

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**

LSJ Counseling & Clinical Services

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____
□ Psychological Testing_____
□ Psychiatric Evaluation_____
□ Intake/Screening Assessment____
□ Criminal Record
□ Other – Specify_____

□ Current Medicine_____
□ Progress Notes/Reports____
□ Substance Abuse Information
□ CCA/Assessments
□Treatment history summary

□ Diagnosis_____
□ Fact of Admission____
□ HIV/AIDS Information_____
□ Education records
□Discharge summary

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, PLLC.
• 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 hospital or physician or call the LSJ Counseling and Clinical 24-hour Crisis Line at (704) 930-4341.
• I understand that this consent for service and treatment is valid for one year provided that all claims for treatment have been paid as provided in any benefit plan.
• 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

Updated 3.24.20

LSJ Counseling & Clinical Services

1905 J N Pease Place
Suite 103
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 $50 cancellation fee. I understand that this charge is not covered by insurance and is my responsibility. I understand that I will be charged $65 should my records have to be provided to another party at my request. I understand I will be charged $65 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.

LSJ Counseling and Clinical Services, PLLC 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 LSJ Counseling and Clinical Services, PLLC . 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 LSJ Counseling and Clinical Services, PLLC 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

LSJ Counseling & Clinical Services

(704) 910-0136

lakesha@lsjcounselingandclinical.com

1905 J N Pease Place
Suite 103
Charlotte NC 28262

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 LSJ Counseling and Clinical Services, PLLC'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:*

_____ _____

LSJ Counseling and Clinical Services, PLLC Staff *Date*

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. Therapy 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, your therapist 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 LSJ Counseling and Clinical Services, PLLC Staff.

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 insurance as she is out of network.

Counseling sessions usually last **50 to 55 minutes**. The charge starts at **$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, PLLC), 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, PLLC 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 the director via email (lakesha@lsjcounselingandclinical.com) or voicemail (704-910-0136). 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 receive email according to these terms by checking ☐ **YES** or ☐ **NO**.

If yes, email:_____.

I understand and agree to these terms.

Name (Printed): _____

Signed: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____