



Date: _____

DEMOGRAPHIC INFORMATION

Please mark only one box clearly

Last Name	First Name	Middle Name	Suffix <input type="checkbox"/> none <input type="checkbox"/> circle I, II, III, IV <input type="checkbox"/> Jr.	Maiden (required)
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Address:	Social Security Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
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Emergency Contact//Next of Kin:	County of Residence	Home Phone: Please include area code with phone number Cell Phone: Work Phone: Which do you prefer? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
NAME: _____ Phone number: _____ Relationship to client: _____	_____ If applicable, county of Department of Social Services providing Medicaid _____	

Is client a minor or have a legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Relationship: _____ Phone number of legal guardian, if applicable: _____	Proficient in English <input type="checkbox"/> Yes <input type="checkbox"/> No Secondary Language <input type="checkbox"/> N/A <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish	Race <input type="checkbox"/> American Indian/Native American <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Multiracial <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input type="checkbox"/> Hispanic, Cuban <input type="checkbox"/> Hispanic, Other <input type="checkbox"/> Hispanic, Mexican Origin <input type="checkbox"/> Not Hispanic Origin <input type="checkbox"/> Hispanic, Puerto Rico <input type="checkbox"/> Unknown	Marital Status <input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partners <input type="checkbox"/> Separated <input type="checkbox"/> Annulled <input type="checkbox"/> Widowed
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What is your source of income? <input type="checkbox"/> N/A - none <input type="checkbox"/> Earned income <input type="checkbox"/> Disabled – receiving SSI/SSDI <input type="checkbox"/> Disabled – disability request pending (SSI/SSDI) <input type="checkbox"/> Other: _____	What is your Household Size?	What is your ANNUAL income?	Employment <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Student	Living Arrangement <input type="checkbox"/> Homeless (street, vehicle, shelter) Shelter name: _____ <input type="checkbox"/> Nursing Home <input type="checkbox"/> Independent Rooming Home <input type="checkbox"/> Private Residence <input type="checkbox"/> Residential Facility <input type="checkbox"/> Other: _____
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Special Need Accommodations <input type="checkbox"/> N/A <input type="checkbox"/> Wheelchair / Mobility Needs <input type="checkbox"/> Deaf / Hearing Impaired <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Childcare <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Physical Disability <input type="checkbox"/> Frail Senior <input type="checkbox"/> Foreign Language Interpreter <input type="checkbox"/> Other: _____	Education Level: (highest completed) <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> Associate Degree <input type="checkbox"/> Baccalaureate Degree <input type="checkbox"/> Special Education <input type="checkbox"/> Post Graduate Degree <input type="checkbox"/> None, never attended school <input type="checkbox"/> _____ Grade (i.e. 11 th)	Referral Source <input type="checkbox"/> Self – no referral <input type="checkbox"/> School <input type="checkbox"/> Private Physician <input type="checkbox"/> State Facilities <input type="checkbox"/> Other Health Care <input type="checkbox"/> Community Agency <input type="checkbox"/> Family / Friends <input type="checkbox"/> Other Outpatient <input type="checkbox"/> Psychiatric Services/General Hospital <input type="checkbox"/> Other : _____
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Have you been arrested in the past 30 days? <input type="checkbox"/> Yes How many times? _____ <input type="checkbox"/> No	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Veterans Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which war: _____ Who served? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Sibling
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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



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 \$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



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 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



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, PLLC 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. 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 (704-930-4341). 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 receive 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:** _____