

**NEW CLIENT INFORMATION
WELCOME TO OUR OFFICE**

THERAPIST _____ DATE _____

CLIENTS NAME: _____ DOB ____/____/____
LAST M FIRST

HOME ADDRESS: _____
STREET CITY STATE ZIP

EMAIL ADDRESS: _____

HOME PHONE (____) _____ WORK/CELL (____) _____

S.S.# _____ GENDER: MALE ____ FEMALE ____ AGE _____

MARITAL STATUS: MARRIED ____ SINGLE ____ DIVORCED ____ WIDOWED ____ OTHER ____

EDUCATION COMPLETED _____ OCCUPATION _____

EMPLOYER _____

SPOUSE/PARENT EMPLOYER _____

SPOUSE/PARENT NAME _____ DOB ____/____/____ S.S.# _____

RELATIVE TO NOTIFY IN CASE OF EMERGENCY _____

RELATIONSHIP _____ PHONE _____

INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARD TO OFFICE STAFF

INSURANCE COMPANY _____

ID# (SS#) _____ GROUP ID# _____ PHONE # _____

INSURED NAME _____ DOB ____/____/____

RELATIONSHIP TO CLIENT _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

PLEASE LIST EVERYONE IN YOUR FAMILY WITH WHOM YOU PRESENTLY LIVE:

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>NAME</u>	<u>RELATIONSHIP</u>
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS TREATMENT DATES FOR MENTAL HEALTH, OUTPATIENT CARE _____

HOSPITALIZATION DATES _____ FACILITY _____

CURRENT MEDICATIONS: _____

<u>SUBSTANCE USE HISTORY:</u>	<u>CURRENT/AMOUNT</u>	<u>PAST USAGE/DATE</u>
ALCOHOL	_____	_____
MARIJUANA	_____	_____
COCAINE/CRACK	_____	_____
OTHER	_____	_____

LIST ALLERGIES, IF ANY _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

ADDRESS _____

WHAT ARE THE PRIMARY PROBLEMS YOU ARE PRESENTLY EXPERIENCING? _____

WHAT DO YOU EXPECT FROM THERAPY? _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE CLIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I HEREBY AUTHORIZE BEHAVIORAL HEALTH SERVICES OF LKN TO FURNISH INFORMATION TO INSURANCE COMPANIES AND REFERRING PHYSICIANS CONCERNING MY TREATMENT AND I HEREBY ASSIGN TO THE PROVIDER ALL PAYMENTS FOR PROFESSIONAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. THERE WILL BE NO DIVISION OF ACCOUNTS.

DATE _____ SIGNATURE _____

Professional Disclosure Statement
Cynthia C. Lucas, MA, LCMHC, NCC
704-582-3381
cynlucas@carolina.rr.com

You have taken the important first step to pursue counseling with Cynthia Lucas, LCMHC. I realize that starting counseling is a major decision, and you may have many questions. This document contains valuable information about my background, professional services, and your rights. If you have any questions about what is stated in this document or about something not covered in this document, please ask so we may discuss it.

Counseling with Cynthia Lucas:

I view counseling as a move toward life enhancement. Counseling can improve physical, mental, and spiritual wellness, as well as interpersonal relationships. You may have specific issues you are seeking help with, or just want to enhance your general health and wellbeing. I wholeheartedly believe that seeking counseling shows significant strength. Counseling can help you uncover strengths and offer strategies about how to utilize them. I consider it an honor to be an empathetic, non-judgmental presence in an environment where you allow yourself to courageously explore your life. Thank you for the privilege of providing you with counseling.

Qualifications and Professional Orientation:

I earned my Masters Degree in Clinical Mental Health Counseling from the University of North Carolina at Charlotte in December of 2013 and am a member of the American Counseling Association. I am a Licensed Clinical Mental Health Counselor (10649), in the state of North Carolina. I approach my clinical practice from an integrated theoretical model, incorporating elements from CBT, Motivational Interviewing, Solution Focused, and Reality therapies, applying those that are relevant to your needs and goals. Integrated psychotherapy utilizes elements from all available theories, techniques and practices. The integrated model does not conform to one school of thought or system; instead it incorporates what is most relevant from the range of therapeutic interventions. The integrated model embraces contributions from a variety of sources according to their validity, applicability and whether they are an appropriate course of action. I also recognize that the individual is part of a family, community, and society as a whole and is influenced by the impact of these groups on his or her life.

I am bound by the rules and ethical codes of the American Counseling Association, the North Carolina Board of Licensed Professional Counselors, and the National Board for Certified Counselors, and I take these responsibilities seriously. The ACA Code of Ethics (2005) states, *"The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients."* A.1.a. (www.counseling.org). You may refer to the remainder of rules and the code on the website provided. While professional counseling has been scientifically shown to have many benefits such as solutions to specific problems, healthier relationships and improved overall health, there are no guarantees that your problems will be solved by participating in counseling with me. Growth is not an easy process, and you may experience unpleasant feelings as you encounter obstacles; things may become more emotionally difficult before they get better during our work together.

Counseling Background:

I am trained and experienced in working with individuals and groups presenting with a wide range of issues. I work with individuals dealing with grief and loss, anxiety, depression, relationship concerns, chronic pain, and weight management issues. Counseling is collaborative between the counselor and client. In my role as your counselor, I offer a safe and supportive environment in which to help guide and assist you in understanding your thoughts, feelings, behaviors as well as your interpersonal relationships. Throughout the therapeutic process you will be asked to challenge yourself not only in session but outside of session as well, where homework, written exercises, verbal exercises and other types of tasks may be assigned.

Use of Diagnosis:

Diagnosis is established using the guidelines identified in the DSM-V. Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an “illness” before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis will become a part of your PERMANENT insurance records.

Appointments, Fees, and Cancellations:

An individual counseling session is usually between 60 and 75 minutes and the session fee is \$85.00 to \$175.00, payable by cash or check if you are self-paying. You may opt to have us bill your insurance, which often requires a co-pay amount at the time of service. Amounts paid by insurance company will vary depending upon insurance carrier and specific plan and may be applied to deductible. It is suggested that you contact your insurance company to understand the mental health benefits of your policy. **To avoid being charged for a scheduled appointment it must be rescheduled or canceled at least 24 hours in advance.** A missed appointment is a lost opportunity for both you and the counselor. The counselor has reserved that time for you. Other clients have not had access to that appointment time because it was held for you. In addition, your counselor considered that appointment time as an important part of your counseling. While unforeseen emergencies occur, please make every effort to keep your appointment as scheduled. When on occasion I will be unavailable for appointments, I will make every attempt to inform you of this in advance. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary.

Confidentiality:

Mental health professionals have an ethical responsibility and a professional duty to safeguard clients from unauthorized disclosures of information given in the therapeutic relationships. All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) if I am ordered by a court to disclose information.

Registering Complaints:

Although I encourage you to discuss any concerns with me, you may file a complaint with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (<http://www.counseling.org/Resources/aca-code-of-ethics.pdf>).

North Carolina Board of Licensed Clinical Mental Health Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblcmhc.org

Acceptance of Terms:

We agree to these terms and will abide by these guidelines.

Client: _____ Date: _____

Parent or guardian: _____ Date: _____

Counselor: _____ Date: _____

CYNTHIA LUCAS, MA, LCMHC, NCC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of CYNTHIA LUCAS' Notice of Privacy Practices. This notice describes how Cynthia Lucas may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

(Signature of Patient, or Personal Representative) (Date)

(Relationship to Patient)

FINANCIAL WAIVER:

INSURANCE INFORMATION NEEDS TO BE CURRENT AND ACCURATE. OUR OFFICE WILL FILE INSURANCE CLAIMS AS **A COURTESY TO YOU**. YOU ARE EXPECTED TO **PAY ALL DEDUCTIBLE AND CO-PAYMENT AMOUNTS AT THE TIME OF EACH VISIT. ALL COSTS NOT COVERED BY YOUR INSURANCE COMPANY WILL BE YOUR RESPONSIBILITY** OR IN CASE OF A MINOR, THE PARENT/GUARDIAN'S RESPONSIBILITY.

SIGNATURE: _____ DATE: _____

PATIENT RIGHTS AND RESPONSIBILITIES

CYNTHIA LUCAS, MA, LCMHC, NCC

107 KILSON DRIVE, SUITE 202

MOORESVILLE, NC 28117

Confidentiality

Privacy and confidentiality are of the utmost importance to the clinical relationship. Information given by the client remains private and confidential. The therapist will not share information with any person without your written permission, except as required by law or in a situation deemed potentially life-threatening. I grant permission to the therapist to communicate with my emergency contact person if a situation is deemed potentially life-threatening.

Financial

Insurance information needs to be current and accurate. Our office will file insurance claims as a courtesy to you unless you indicate otherwise. You are expected to pay all deductible and co-payment amounts at the time of each visit. Clients are responsible for the payment of all applicable fees at the time of the visit. If you are the parent or guardian of a minor, all costs not covered by your insurance company will be your responsibility. The office does not become involved with division of accounts between divorced parents.

Appointments

*Appointments are scheduled as a forty-five to fifty-minute therapeutic hour. In the event that you must cancel an appointment, please call the office at **704-660-8321** at least 24 hours in advance. **Failure to give adequate notice may result in your being billed for the appointment.***

Office hours begin at 9AM weekdays and evening hours are determined by each individual therapist. Due to the limited space for evening hours, please be mindful of the importance of advance notice if you are unable to keep an evening appointment.

Managed Care Clients

Most managed care plans require pre-approval for mental health and chemical dependency services. Non-compliance could lead to denial of benefits (payments for services). If you have entered therapy with this office under a managed care plan, please check with the office manager to verify approval for services.

Under some managed care plans, the therapist is required to provide clinical information to a case manager after the initial session if additional sessions are needed. If you have any questions about this procedure, please feel free to discuss this with the therapist. Managed care companies are often required to carry out quality assurance practices. Audits by the managed care plan may be conducted, but information identifying your participation in the program will not be disclosed to the auditor.

SIGNATURE: _____ **DATE:** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CYNTHIA LUCAS, MA, LCMHC, NCC MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

CYNTHIA LUCAS, MA, LCMHC, NCC is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Cynthia Lucas, MA, LCMHC, NCC or received by Cynthia Lucas, MA, LCMHC, NCC from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this notice. Cynthia Lucas, MA, LCMHC, NCC will abide by the terms of this notice, or the notice currently in effect at the time of the use or disclosure of your protected health information.

Cynthia Lucas, MA, LCMHC, NCC reserves the right to change the terms of this notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised notices upon request. An individual may obtain a copy of the current notice from our office at any time.

Uses and disclosures of your protected health information not requiring your consent

Cynthia Lucas, MA, LCMHC, NCC may use and disclose your protected health information, without your written consent or authorization for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Cynthia Lucas, MA, LCMHC, NCC may determine that you require the services of a specialist. In referring you to another doctor, Cynthia Lucas, MA, LCMHC, NCC may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Cynthia Lucas, MA, LCMHC, NCC to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Cynthia Lucas, MA, LCMHC, NCC will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Cynthia Lucas, MA, LCMHC, NCC may use your diagnosis, treatment and outcome information to measure the quality of the service that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Cynthia Lucas, MA, LCMHC, NCC may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Cynthia Lucas, MA, LCMHC, NCC is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- For public health activities.
We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

This notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records including treatment records or HIV test results to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary, to prevent serious harm. Records may be released for the reporting of domestic violence if necessary, to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
We may disclose healthcare records, including treatment records, in response to a written request by any federal or state government agency to perform legally authorized functions such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state government agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.
- Judicial and Administrative Proceedings.
Patient healthcare records, including treatment records or HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.
- For activities related to death.
We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- For research.
Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To avoid a serious threat to health or safety.
We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- For workers' compensation.
We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Cynthia Lucas, MA, LCMHC, NCC will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Cynthia Lucas, MA, LCMHC, NCC has taken action in reliance thereon. Any revocation must be in writing.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Cynthia Lucas, MA, LCMHC, NCC to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Cynthia Lucas, MA, LCMHC, NCC may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Cynthia Lucas, MA, LCMHC, NCC send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Cynthia Lucas, MA, LCMHC, NCC not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Cynthia Lucas, MA, LCMHC, NCC amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Cynthia Lucas, MA, LCMHC, NCC for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this notice, if you had previously received or agreed to receive the notice electronically.

Any person or patient may file a complaint with Cynthia Lucas, MA, LCMHC, NCC and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Cynthia Lucas, MA, LCMHC, NCC, please contact the Privacy Officer at the following:

CYNTHIA LUCAS, MA, LCMHC, NCC
ATTN: PRIVACY OFFICER
107 KILSON DRIVE, SUITE 202, MOORESVILLE, NC 28117
704-660-8321

It is the policy of Cynthia Lucas, MA, LCMHC, NCC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003

Cynthia Lucas, MA, LCMHC, NCC
107 Kilson Drive, Suite 202, Mooresville, NC 28117

Client Name: _____
DOB: _____ **Record #:** _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I _____ hereby authorize Cynthia Lucas, MA, LCMHC, NCC to release specified information below
(Client or Personal Representative)
to _____. I also hereby authorize _____
to release specified information to Cynthia Lucas, MA, LCMHC, NCC.

Reason for Referral	History of Psychotropic Medication Use
Psychiatric	School Academic Achievement and Behavior
Psychological	Complete Medical Record for Monitoring and Review
Social	Complete Administrative Record
Medical Information	Substance Abuse Information
Current medications	Other:
HIV or AIDS related Information	Other:

I understand this information will be used for: _____.

I understand that this authorization will expire on the following date, event or condition: _____.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

Signature of Client

Date

Signature of Personal Representative/Relationship

Date

Annual Renewal or Change of Guardianship:

Signature of Personal Representative

Signature of Personal Representative

Signature of Personal Representative

Date

Date

Date

Personal Representative Relationship/Authority

Personal Representative Relationship/Authority

Personal Representative Relationship/Authority

NOTE: This Authorization was revoked on _____
Date

Signature of Staff