

**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**  
**Michael E. Rife, LCMHC, LCAS, SAP**  
License 2215

It is required by the North Carolina Board of Licensed Mental Health Counselors that you are provided with the following statement, prior to receiving services. Please read the following statement carefully and sign and date the form at the bottom.

- ♦ Education and Licensing
    - ♦ Licensed Professional Counselor 1995
    - ♦ 2012 – EMDR Training – Part One
    - ♦ 1993 – M.Ed. – Community Agency Counseling from East Tennessee State University
  - ♦ Work with the following populations:
    - ♦ Children/Adolescents 12-19 years old
    - ♦ Adults
  - ♦ Experience and training:
    - ♦ Children and Adolescents – Individual and Group
    - ♦ Grief, Loss and Trauma Counseling
    - ♦ OCD
    - ♦ Couples and Family Counseling
    - ♦ School-based Counseling
    - ♦ Various types of Group Counseling – grief, anger management, social skills and life transitions
    - ♦ Anger and Stress Management
  - ♦ Theoretical orientation is based primarily on a Client-Centered, Rational Emotive Therapy, and CBT\*
    - ♦ Listen to clients in an empathic, nonjudgmental way
    - ♦ Respect the client’s current emotional state and provide a safe and secure environment for our sessions
    - ♦ Explore the client’s spiritual belief system
  - ♦ The techniques used will vary based upon client’s emotional and mental state, age, issue(s), goals and time restraints. The following are the techniques most commonly used.\*\*
    - ♦ CBT and RET - explore behavioral patterns and exposure to assist with anxiety reduction
    - ♦ Dream Analysis - utilizing dreams to uncover unconscious emotions
    - ♦ EMDR - process to aid in recovery and processing of traumatic memories
  - ♦ Sessions are fifty minutes in length and the fee is \$150.00 for initial session and \$120.00 for all other sessions. Payable by cash, check, or credit/debit card. A \$25.00 fee will be applied for NSF. Additional fees may be applied for administrative tasks and school meetings.
  - ♦ Payment is due at time of session. Please kindly give 24-hour cancellation notice. *Missed appointments may be charged \$50.00.*
  - ♦ Diagnosis is used primarily to provide client with a proper treatment plan and may be necessary for insurance coverage. The diagnosis becomes part of the client’s record.
  - ♦ Confidentiality is kept between the counselor and client except in the following cases:
    - ♦ Client reports or indicates any ideations or actions which involve harm to self or others
    - ♦ Any indication of child or elder abuse
    - ♦ Court Order
    - ♦ As noted above insurance may require a diagnosis and treatment plan for coverage
  - ♦ In the event that the client feels a complaint must be filed the following procedure applies:
    - ♦ Discuss the issue with the counselor – every effort will be made to resolve the issue
    - ♦ If the issue is not resolved the client may submit a complaint in writing to North Carolina Board of Licensed Mental Health Counselor at P.O. Box 77819, Greensboro, NC, 27417. Phone: 844-622-3572
- \*Other theoretical modalities may be used depending upon client needs and situation  
\*\*Many other techniques may be used throughout treatment  
\*\*\*Therapy is not a guarantee of mood, emotion, or behavior change.

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Client’s Signature and date

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Counselor’s signature and date

**PATIENT RIGHTS AND RESPONSIBILITIES**  
**BEHAVIORAL HEALTH SERVICES OF LKN**  
**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:** \_\_\_\_\_

**BEHAVIORAL HEALTH SERVICES OF LKN**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ acknowledge that I have received a copy of Behavioral Health Services of LKN’s Notice of Privacy Practices. This notice describes how Behavioral Health Services of LKN 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.

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

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(Relationship to Patient)

**MICHAEL E. RIFE, LCAS, LCMHC, SAP  
107 KILSON DRIVE, SUITE 202  
MOORESVILLE, NC 28117  
PHONE: 704-660-8321 FAX: 704-660-8323**

**RELEASE OF INFORMATION FORM**

I, \_\_\_\_\_, authorize Michael E. Rife, LCAS, LCMHC, SAP to release to/obtain from:  
(Client name)

\_\_\_\_\_  
(Name of provider, facility, or individual)

The following information:

- |   |   |
|---|---|
| <input type="checkbox"/> Discharge Summary                        | <input type="checkbox"/> Assessment, Tx Plans/Summary of Patient Progress |
| <input type="checkbox"/> Psychiatric History                      | <input type="checkbox"/> Physician Orders                                 |
| <input type="checkbox"/> Medical History/Physical Exam            | <input type="checkbox"/> Progress Notes or Summary of Progress Notes      |
| <input type="checkbox"/> Clinical Lab, X-Ray, EKG, EEG, CT Scan   | <input type="checkbox"/> Occupation/Recreational Therapy                  |
| <input type="checkbox"/> Consultations (Psych, Neuro, etc.)       | <input type="checkbox"/> Educational Information                          |
| <input type="checkbox"/> Compliance with treatment/recommendation | <input type="checkbox"/> Attendance                                       |
| <input type="checkbox"/> Other                                    | <input type="checkbox"/> Drug Screen Results                              |

This authorization shall become effective \_\_\_\_\_ and is subject to revocation in writing by the undersigned at any time except to the extent that action has already been taken and shall TERMINATE ONE YEAR from the effective date if not earlier revoked.

\_\_\_\_\_  
(Specify date or circumstances under which consent will expire)

I understand that the information designated above will be the only information released and will not be disclosed to any other person or agency without my written permission. I understand that I have the right to receive a copy of this consent upon request. I understand that, upon disclosure by Michael E. Rife of information released pursuant to this authorization, Michael E. Rife no longer has control of such information.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Therapist/Witness

\_\_\_\_\_  
Date

**MICHAEL E. RIFE, LCAS, LCMHC, SAP  
107 KILSON DRIVE, SUITE 202  
MOORESVILLE, NC 28117  
PHONE: 704-660-8321 FAX: 704-660-8323**

**PERMISSION TO CONTACT PRIMARY CARE PHYSICIAN**

I, \_\_\_\_\_, authorize Michael E. Rife, LCAS, LCMHC, SAP to release to/obtain from:  
(Client name)

\_\_\_\_\_ my primary care physician.

Purpose of this contact is to coordinate treatment.

Providers Address \_\_\_\_\_

Providers Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

This authorization shall become effective \_\_\_\_\_ and is subject to revocation in writing by the undersigned at any time except to the extent that action has already been taken, and shall TERMINATE ONE YEAR from the effective date if not earlier revoked.

\_\_\_\_\_  
(Specify date or circumstances under which consent will expire)

I understand that the information designated above will be the only information released and will not be disclosed to any other person or agency without my written permission. I understand that I have the right to receive a copy of this consent upon request. I understand that, upon disclosure by Michael E. Rife of information released pursuant to this authorization, Michael E. Rife no longer has control of such information.

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Parent/Guardian Date

\_\_\_\_\_  
Signature of Therapist/Witness Date

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: \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MICHAEL E. RIFE, LCAS, LCMHC, SAP MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MICHAEL E. RIFE, LCAS, LCMHC, SAP 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 Michael E. Rife, LCAS, LCMHC, SAP or received by Michael E. Rife, LCAS, LCMHC, SAP 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. Michael E. Rife, LCAS, LCMHC, SAP 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.

Michael E. Rife, LCAS, LCMHC, SAP 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

Michael E. Rife, LCAS, LCMHC, SAP 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, Michael E. Rife, LCAS, LCMHC, SAP may determine that you require the services of a specialist. In referring you to another doctor, Michael E. Rife, LCAS, LCMHC, SAP may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Michael E. Rife, LCAS, LCMHC, SAP 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, Michael E. Rife, LCAS, LCMHC, SAP 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, Michael E. Rife, LCAS, LCMHC, SAP 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.

Michael E. Rife, LCAS, LCMHC, SAP 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 Michael E. Rife, LCAS, LCMHC, SAP 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 investigation 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.

Michael E. Rife, LCAS, LCMHC, SAP 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 Michael E. Rife, LCAS, LCMHC, SAP 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 Michael E. Rife, LCAS, LCMHC, SAP 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. Michael E. Rife, LCAS, LCMHC, SAP 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 Michael E. Rife, LCAS, LCMHC, SAP send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Michael E. Rife, LCAS, LCMHC, SAP 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 Michael E. Rife, LCAS, LCMHC, SAP 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 Michael E. Rife, LCAS, LCMHC, SAP 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 Michael E. Rife, LCAS, LCMHC, SAP and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Michael E. Rife, LCAS, LCMHC, SAP, please contact the Privacy Officer at the following:

MICHAEL E. RIFE, LCAS, LCMHC, SAP  
ATTN: PRIVACY OFFICER  
107 KILSON DRIVE, SUITE 202, MOORESVILLE, NC 28117  
704-660-8321

It is the policy of Michael E. Rife, LCAS, LCMHC, SAP 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