**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:**

**NAME RELATIONSHIP NAME RELATIONSHIP**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREVIOUS TREATMENT DATES FOR MENTAL HEALTH, OUTPATIENT CARE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOSPITALIZATION DATES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FACILITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SUBSTANCE USE HISTORY: CURRENT/AMOUNT PAST USAGE/DATE**

 **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Record #: \_\_\_\_\_\_\_\_\_\_\_\_** |

Paul D. Veach, MS, LMFT, LCAS

107 Kilson Dr, Suite 202 Mooresville, NC 28117

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Paul D. Veach, MS, LMFT, LCAS to release specified information below

 *(Client or Personal Representative)*

to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I also hereby authorize \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release specified information to Paul D. Veach, MS, LMFT, LCAS.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 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 Signature of Personal Representative/Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date

*Annual Renewal or Change of Guardianship:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Personal Representative Date Personal Representative Relationship/Authority*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Personal Representative Date Personal Representative Relationship/Authority*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Personal Representative Date Personal Representative Relationship/Authority*

 *\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* \*\*\*\*\*\*\*\*\*\**

*NOTE: This Authorization was revoked on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Date Signature of Staff*

**PROFESSIONAL DISCLOSURE STATEMENT/CONSENT FOR TREATMENT**

**PAUL D. VEACH, MS, LMFT, LCAS**

**107 Kilson Drive, Suite 202**

**Mooresville, NC 28117**

**704-660-8321**

Paul D. Veach, MS, LMFT, LCAS is presently license as a Marriage and Family Therapist with supervisory status and Licensed Clinical Addictions Specialist with professional education and degrees as earned at:

**INSTITUTION MAJOR DATE AWARDED DEGREE**

 University of Dayton Counseling August, 1994 M.S.

 Mt. Vernon Nazarene College Psych./Bus. Admin. June, 1991 B.A.

 Appalachian State University Marriage/Family December, 2001 Non-Degree (9 sem. hrs.)

 Chemical Dependency June, 2004 Non-Degree (12 sem. hrs.)

**CURRENT CREDENTIALS**

Licensed Marriage and Family Therapist (LMFT) in the state of North Carolina, License #928

Licensed Clinical Addictions Specialist (LCAS) in the state of North Carolina, License #1810

Licensed School Counselor (Grades K-12)

Level II training in Eye Movement Desensitization and Reprocessing (EMDR)

AAMFT Approved Supervisor, 2/7/05 – present, Member #82172

**PROFESSIONAL EXPERIENCE AND SERVICES**
Entered the helping professions in 1991 and have been providing therapy at the Master’s license level since 1997. Area of focus in practice include but are not limited to family, marital, individual and group therapy for all ages, treatment of trauma, disruptive behaviors, and other emotional and mental disorders.

Provide Therapy, consultation, and clinical supervision from a Family Systems theoretical perspective. This perspective focuses on how family members and their issues are interdependent, and emphasizes strengths over weaknesses. The cultural, spiritual, and individual differences of the client and family are also valued by the Family Systems perspective. Genograms, timelines, enactments, and role-plays are examples of techniques used in this approach. Specific interventions are also used in the treatment of trauma and attachment issues, such as relaxation techniques, guided imagery, and EMDR.

**FEES FOR SERVICE**

A therapy hour is equal to 50 minutes of direct contact with the remaining 10 minutes generally devoted to documentation. The rates for individual, family and marital therapy are set at $120 an hour and $150 for the initial intake. Following the initial intake, these fees may be reduced according to taxable income for clients who qualify. Payments may be made by cash, check, or Square debit. Out of pocket fees are $100 per session. No show fees and late cancellation fees (less than 24 hours’ notice) are $75.

**BENEFITS AND RISKS OF TREATMENT**

Desired results of treatment cannot be guaranteed, and there is the risk that the conditions the client seeks treatment for may continue to increase or remain unchanged. Clients may request recommendations for a transfer to another provider when it’s determined that treatment is not progressing as expected, when it is determined that an alternative form of treatment may be called for, or at any other time the client wishes to do so.

**CONFIDENTIALITY AND ETHICS**

The documentation of diagnosis may be necessary during the course of treatment and this information along with general information in the progress notes is privileged, and requires that a release of information be signed by the client or legal guardian for these records to be shared outside this setting. The following exceptions may apply; 1. In the event that it is determined that there is a reasonable risk of harm to self or others, 2. The client or guardian is incapacitated and such information is needed for emergency care, 3. There is evidence or allegation of child/adult abuse, 4. A court order is issued for the release of information.

If you ever have concerns regarding what you believe to be a violation of your rights as a clients or with the professionalism of care you have received and do not believe you have or can successfully resolve the issue directly with the provider according to the procedures outlined on the Notice of Privacy Practices that was included with the intake forms, you may register a complaint with the **North Carolina Marriage and Family Therapy Licensure Board at: P.O. Box 37669, Raleigh, NC 27627 (919) 469-8081 or the North Carolina Substance Abuse Professional Practice Board at: P.O. Box 10126, Raleigh, NC 27605 (919) 833-5743** and they will assist you.

I have received a copy of this **Professional Disclosure Statement**, the **Notice of Privacy Practices** and have reviewed documents related to billing and storage of records. I am satisfied with the explanations provided. I voluntarily consent to receive treatment as outlined by this disclosure statement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Client Date Parent/Guardian Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Date Other 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

# 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAUL D. VEACH, MS, LMFT, LCAS**

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

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_acknowledge that I have received a copy of Paul D. Veach’s Notice of Privacy Practices. This notice describes how Paul D. Veach 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)

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW THE COUNSELING SERVICES OF PAUL D. VEACH, MS, LMFT, LCAS AND BEHAVIORAL HEALTH SERVICES OF LAKE NORMAN (BHS OF LKN) MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS

INFORMATION. PLEASE REVIEW IT CAREFULLY.

Paul D. Veach, MS ,LMFT, LCAS and BHS of LKN 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 Paul D. Veach, MS, LMFT, LCAS and BHS of LKN or received by Paul D. Veach, MS, LMFT, LCAS and BHS of LKN from other healthcare providers.

Paul D. Veach, MS ,LMFT, LCAS and BHS of LKN 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. Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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.

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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.

Business Relationship to Behavioral Healthcare Services of Lake Norman (BHS of LKN)

Paul D. Veach, MS, LMFT, LCAS sublets office space from (or pays rent to) BHS of LKN. As part of this financial agreement with BHS of LKN, Paul D. Veach, MS, LMFT, LCAS also receives secretarial and billing services from BHS of LKN. Paul D. Veach, MS, LMFT, LCAS is not an employee of or co-business owner of BHS of LKN. Paul D. Veach, MS, LMFT, LCAS does not share in profits generated by BHS of LKN or receive financial incentives for referring clients to BHS of LKN.

Privacy Practices Between Paul D. Veach, MS,LMFT, LCAS and BHS of LKN

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN has access to your healthcare information for the purposes of billing for services, maintaining records, and the scheduling of appointments. Your healthcare information is not available to other mental health providers who may also sublet space or practice on the premises (107 Kilson Dr. Suite 202 Mooresville, NC 28117) without your expressed written consent. In the event that you are referred to another mental health provider who provides services on the premises, an authorization of disclosure or release of information will be acquired prior to the sharing of healthcare information. Likewise, the healthcare information generated by clients served by other mental health providers on the premises is not available to Paul D. Veach, MS, LMFT, LCAS without the expressed written consent of the client(s).

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

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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, Paul D. Veach, MS, LMFT, LCAS and BHS of LKN may determine that you require the services of a specialist. In referring you to another doctor, Paul D. Veach, MS, LMFT, LCAS and BHS of LKN may share or transfer your healthcare information to that doctor.

 Payment activities may include:

* Activities undertaken by Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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, Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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, Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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.

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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 Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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.

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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. Paul D. Veach, MS, LMFT, LCAS and 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. Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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.

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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.

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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, Paul D. Veach, MS, LMFT, LCAS and BHS of LKN may use and disclose your health information to help conduct research.

* To avoid a serious threat to health or safety.

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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.

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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 Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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 Paul D. Veach, MS, LMFT, LCAS and BHS of LKN to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. Paul D. Veach, MS, LMFT, LCAS and BHS of LKN are not required to agree to your request, but if we do agree, Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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. Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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 Paul D. Veach, MS, LMFT, LCAS and BHS of LKN send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that BHS of LKN 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 Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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 Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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 Paul D. Veach, MS, LMFT, LCAS and BHS of LKN and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with BHS of LKN, please contact the Privacy Officer at the following:

 PAUL D. VEACH, MS, LMFT, LCAS/BEHAVIORAL HEALTH SERVICES OF LKN

ATTN: PRIVACY OFFICER

 107 KILSON DRIVE, SUITE 202, MOORESVILLE, NC 28117

 704-660-8321

It is the policy of Paul D. Veach, MS, LMFT, LCAS and BHS of LKN 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. Complaints will receive an initial response within two business days of the complaint being received. The length of time required to resolve the complaint thereafter may vary, depending on the nature of the circumstances.

This Notice of Privacy Practices is effective April 14, 2003. Last Revised on December 14, 2009.