Family Ties Mental Health Counseling Services
Intake and Consent

720 North 3rd St. Suite 401
Wilmington, NC 28401
Phone: (910) 769-9126
Fax: (910) 769-9169

5320 Bridgers Road
Shallotte, NC 28470
Phone: (910) 769-9126
Fax: (910) 769-9169

Record #
_____ Admission Date _____ Discharge Date _____

IDENTIFYING INFORMATION

NAME: _____ DOB: _____

GENDER AT BIRTH (Please check one) _____ Female _____ Male GENDER IDENTIFICATION: _____

MARITAL STATUS: _____ SOCIAL SECURITY NUMBER: _____

RACE: ___African American ___Caucasian ___Hispanic ___Bi-Racial ___Other

ADDRESS:_____

COUNTY OF RESIDENCE: _____ SCHOOL: _____

CELL PHONE: _____ WORK/OTHER PHONE: _____

EMAIL ADDRESS: _____

COMPETENCY STATUS: ____Competent Adult ____Incompetent adult with an appointed guardian ____Minor

ADDITIONAL INFORMATION FOR MINORS AND INCOMPETENT ADULTS

NAME OF LEGAL GUARDIAN(S): _____

RELATIONSHIP: _____PARENT'S MARITAL STATUS: _____

MOTHER'S NAME: _____ MOTHER'S PHONE: _____

MOTHER'S ADDRESS: _____MOTHER'S EMAIL: _____

FATHER'S NAME: _____FATHER'S PHONE: _____

FATHER'S ADDRESS: _____FATHER'S EMAIL: _____

FEE AGREEMENT AND INSURANCE INFORMATION

LIST ALL INSURANCES AND POLICY NUMBERS

_____Medicaid _____

_____Health Choice _____

_____Medicare _____

_____Private Insurance _____ Effective Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Policy #: _____ Plan Code: _____Group #: _____

Policy Holder's Name: _____ DOB: _____

Address: _____ Relationship to Client: _____

Employer: _____ Phone#: _____

PLEASE READ AND **INITIAL** EACH STATEMENT BELOW:

_____ I hereby assign payment of insurance benefits to Family Ties of Brunswick, LLC. I understand that I will be responsible for some portion of the cost of my services unless Medicaid, IPRS funds or my insurance company pays 100% of the charges billed to them. In the event that Family Ties of Brunswick, LLC is unable to file my claim, I understand that I am responsible for paying the fee for services and filing the insurance claim myself and that if I do not provide information necessary to file for insurance reimbursement, I will be responsible for the full charge for services rendered. I hereby authorize Family Ties of Brunswick, LLC and all other parties to release information required for filing my claim and information regarding potential eligibility for benefits. I agree to Family Ties of Brunswick, LLC of any charges in my insurance coverage and Medicare/Medicaid benefits.

_____ I understand the following information is intended to serve as a guideline only. Fee requirements can change at any time based on North Carolina regulations and Medicare/Medicaid requirements. All questions regarding fees should be referred to the Family Ties of Brunswick, LLC Corporate Office.

Therapy/Outpatient Treatment:

Fees for adult consumers receiving therapy/psychiatric treatment are typically as follows:

-50% of the service rate for Medicare recipients

-Co-payments and/or deductibles as determined by the insurance carrier for consumers with private insurance.

Fees for child consumers receiving therapy/psychiatric treatment are typically as follows:

-$0.00 per visit for Medicaid or Health Choice recipients

-Co-payments and/or deductibles as determined by the insurance carrier for consumers with private insurance.

LIST ALL KNOWN MEDICAL CONDITIONS: _____

LIST ALL KNOWN ALLERGIES: _____

_____

CURRENT MEDICATIONS: REASON:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE READ AND **INITIAL** EACH OF THE STATEMENTS BELOW:

_____I request admission for evaluation, treatment, or habilitation. Should staff determine that admission for services is appropriate, I consent to treatment as necessary. The alleged benefits, potential risks, and possible alternative methods of treatment have been explained to me. If the Comprehensive Clinical Assessment indicates that I would not benefit from services available through Family Ties of Brunswick, LLC I will be referred to a more appropriate resource for assistance. I understand that I may withdraw from services at any time by notifying Family Ties of Brunswick, LLC staff either verbally or in writing of my decision.

_____ I hereby grant permission to Family Ties of Brunswick, LLC to leave messages on my home answering machine if I am not available. I understand that certain medical and personal information may be contained in a computerized record keeping system for reimbursement, statistical, and program planning purposes.

_____ I hereby grant Family Ties of Brunswick, LLC to utilize text messaging services/or secured email for appointment reminders and sending and receiving correspondence (without PHI) related solely to treatment coordination or sessions/appointments.

_____ I have received a copy of the Family Ties of Brunswick, LLC Notice of Privacy Practices (*Pg. 6 & 7*) and have been given the opportunity to ask questions. I understand and have been afforded the opportunity to ask questions regarding examples of when my protected health information can be released/disclosed with or without consent.

_____ I hereby authorize Family Ties of Brunswick, LLC to provide notice to me by phone or verbally in the event of a breach of my protected health information (PHI). I understand such notification will be documented by Family Ties of Brunswick, LLC.

_____ I understand that if receiving treatment in a group setting, I am obligated to keep all information confidential and agree to refrain from disclosing any information discussed.

I understand the statements contained within this intake and consent form and have provided accurate information to the best of my ability. The consents shall be valid for one year unless I decide to revoke them sooner or to the extent that action based on this consent has been taken. Additional information not outlined within this consent form will not be released to third parties unless I sign an Authorization to Release Information Form indicating my agreement with the release of protected health information.

By signing this form, I acknowledge my full consent to treatment with Family Ties of Brunswick, LLC. I have been informed of my right to refuse treatment and have discussed with staff additional reasons why services may be terminated, or I may be discharged from care. I have been informed of the right to consent or to refuse treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability.

_____ _____

Signature Date

Family Ties Mental Health Counseling Services

Consent of Treatment

I, _____, have discussed with the staff of Family Ties of Brunswick, LCC and agreed to receive the following indicated/requested services with independent providers.

Please Initial Below:

_____Assessment ____Outpatient therapy ____Psychiatric Services

____Medication Management ____Other

I understand that Family Ties of Brunswick, LLC provides services that are medically necessary. Other provider services were reviewed with me, and I understand that I may choose another provider at any time with linkage assistance from my current agency. I have also been informed of my rights to change providers later in my treatment for any reason.

My signature below reflects my understanding of my rights, my consent of such services and my full participation and freedom of choice in the treatment planning process. I also understand if any additional services not already indicated may be recommended, I will have further opportunity to participate in the planning of such services. I understand I can withdraw my consent at any time unless I have been ordered to receive such services by court order.

I was asked about my cultural preferences (including my choice as consistent with my values, customs, and beliefs), and if the location of service delivery was appropriate. I was asked if I would prefer a service provider of a particular gender, race, or ethnicity. I selected the above-mentioned agency, considering my choices and preferences.

Parent/Legal Guardian Signature: _____Date_____

Consumer Signature: _____Date_____

Witness Signature: _____Date_____

Family Ties Mental Health Counseling Services

Emergency Contacts

I, _____(Consumer), and _____(Legal Guardian), give Family Ties of Brunswick, LLC and the providers of Family Ties of Brunswick, LLC permission to access the following contacts in case of an emergency and to provide medical attention if means necessary to my child.

I have a Health Care Power of Attorney. _____ No _____ Yes (If yes, put documentation with PCP)

Emergency Contact Person(s)

Name: _____ Relationship: _____

Address: _____

Phone: _____

Name: _____ Relationship: _____

Address: _____

Phone: _____

Emergency Medical

Preferred Physician's Name: _____

Relationship: _____ Phone: _____

My signature below indicates that I grant Family Ties of Brunswick, LLC to contact the above-named individuals in case of an emergency, sudden illness, or accident. I further grant permission to Family Ties of Brunswick, LLC to seek emergency care for me/my child from emergency services, a hospital, or a physician.

Parent/Legal Guardian Signature: _____Date:_____

Consumer Signature: _____Date:_____

Witness Signature: _____ Date:_____

Family Ties Mental Health Counseling Services

Practice Policies

Appointments & Cancellations:

The standard meeting time for psychotherapy is 60 minutes. It is up to you, however, to determine the length of your sessions. Requests to change the 60-minute standard session time need to be discussed with your therapist in advance so your time/schedule may be adjusted accordingly.

Appointments may be in person or via teletherapy.

Please remember to cancel or reschedule your appointment at least 24 hours in advance. There will be a cancellation fee of $50.00 if not cancelled prior to the scheduled visit. After two no show you will be discharged from the practice. Our office hours are 9 a.m. to 5 p.m., Monday through Friday. If you call to cancel/reschedule before or after office hours, please leave a detailed voicemail and a staff member will return your call. **In case of an emergency, please call 911**.

Telephone Accessibility:

If you need to contact Family Ties of Brunswick, LLC between scheduled sessions, please call to speak with a Family Ties staff member or leave a detailed message on our voicemail and expect a call to be returned as soon as your therapist can do so.

Social Media and Telecommunication:

The staff of Family Ties of Brunswick, LLC prioritizes your confidentiality. Our staff does not accept friend or contact requests from current or former clients on any social media networking sites. It is up to your therapist, however, if they choose to release their private cell phone number to you for communication.

Electronic Communication:

Family Ties of Brunswick, LLC cannot ensure the confidentiality of any form through electronic media, including text messages. If you prefer to communicate via email or text for issues regarding your appointment, we will do so. While we try to return your messages in a timely manner, we cannot guarantee an immediate response. We request you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Service by electronic means includes, but is not limited to, service via telephone communication, internet, facsimile machines, and/or e-mail. These are considered methods of telemedicine by the state of NC. If you and your therapist choose to use telemedicine for your treatment, it must be noted that you understand:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care/treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available (fees may vary).

4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

Minors

If you are a minor, your parents are legally entitled to some information about your therapy. Your therapist will discuss with you and your parents about what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Termination

Ending relationships can be difficult. Therefore, it is important to have a termination process to achieve closure. The appropriate length of the termination process depends on the length and intensity of your treatment. Your therapist will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of termination with you. If therapy has been terminated, your therapist will provide you with a list of qualified psychotherapists to treat you if needed. You may also choose someone on your own or from another referral source.

Should you fail to show for 2 appointments, unless other arrangements have been made in advance, for legal and ethical reasons, Family Ties of Brunswick, LLC has the option to consider the professional relationship discontinued and/or have ongoing scheduled appointments cancelled.

BY SIGNING BELOW, I AGREE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE POLICY CONTAINED IN THIS DOCUMENT.

_____

Signature Date

_____

Witness Signature Date

Family Ties Mental Health Counseling Services

Consent to Release

Date: _____

I authorize: _____
(School, Primary Care, DSS, Hospital, etc.)

Address: _____

To release information for: _____ DOB: _____

To: Family Ties and independent providers

Please **initial** information to be given: _____Verbally _____In Writing _____By Fax _____Electronically (HIPPA Compliant)	Please **initial** specific Information: _____Assessments/Evaluations _____Treatment Plans/Plan of Care _____Crisis Plan _____Progress Notes _____Discharge Summary _____Other (Specify)_____

This consent is specifically for coordination of care, and is valid until (may not exceed one year): _____

I understand information released regarding my treatment may include information pertaining to psychiatric treatment, drug abuse, and/or alcoholism (per Federal Law 42 CFR Part 2), acquired immunodeficiency syndrome (AIDS) or Human Immunodeficiency Virus (HIV).
The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibits anyone from making further disclosure without specific written client consent, or as otherwise permitted by such regulations.
I, the undersigned, authorize release of the above information to the person(s) or agencies listed below I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Regional Director of Family Ties of Brunswick, LLC. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release or revoking this release.

Parent/Legal Guardian Signature_____ Date_____

Consumer Signature_____ Date_____

Witness Signature_____ Date_____

Family Ties Mental Health Counseling Services

Practice Modality and Medication Management

Family Ties is a mental health and substance abuse counseling service that also offers medication management for patients who, with their counselor, decide it is necessary.

PLEASE READ AND INITIAL EACH OF THE STATEMENTS BELOW

_____ I understand that to receive medication management from Family Ties, I may be required to attend counseling on at least a monthly basis. If I am required to attend counseling and have not seen a counselor within 30 days (about 4 and a half weeks) of my appointment with the doctor, the appointment will be cancelled.

_____ I understand that if I cancel my appointment with the doctor, or it is cancelled due to not having seen a counselor in an acceptable timeframe, I may not receive my new medications before I am out of my current Medications.

_____ I understand that if I believe that counseling is no longer necessary then I may be referred to my primary care for medication management and discharged from the practice.

_____ I understand that I will be required to give a urine or saliva sample on a regular basis while receiving medication management service through Family Ties.

Parent/Legal Gaurdian Signature _____ Date _____

Consumer Signature _____ Date _____

Witness Signature _____ Date _____