

Client Data Sheet (Adult)

Please Print

Date: _____ Referred by: _____

Name: (as listed on ins. card) _____

Nickname: _____ Social Security # ____ - ____ - ____

Home address: _____

City State Zip

Phones: home _____ work _____ cell _____

Date of Birth: mo ____ day ____ year ____ Age: ____

Occupation: _____ Employer: _____

Business Address: _____

City State Zip

How long in present job? _____

Who may we contact in case of emergency?

Name	Phone (home)	Phone (other)

Current relationship status (check one): ____ Single; ____ Married (date) _____;
 ____ Live-in relationship (date) _____; ____ Separated (date) _____;
 ____ Divorced (date) _____; ____ Widow/er (date) _____

Spouse/partner name _____ Date of Birth _____ Age _____

Occupation of spouse/partner _____ Employer _____

Spouse/partner Social Security #: _____

Previous marriages/live-in relationships:

1st from _____ to _____ 2nd from _____ to _____

3rd from _____ to _____ 4th from _____ to _____

Children:

Name	Sex	Age	Place of Residence
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What religion were you brought up in? _____

Religious Preference Now _____

Where did you live for the 1st 15 years of your life? (city and state)

Education (highest level completed) _____

Parents living together? ____ yes ____ no, because of _____ (death, divorce, etc)

If parents are not living together, is father remarried? ____yes____no
mother remarried? ____yes____no

Brothers & sisters (including half or step)

Name	Sex	Age	Date of Birth & Hometown
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History of Mental Health (relative, diagnosis & year): _____

Family History of Chemical Dependency (who & year): _____

Personal Health Problems (diagnosis & year): _____

Personal Medications: _____

Hospitalizations (diagnosis & year): _____

Previous counseling, type(s) & date(s) _____

Name of counselor(s) & location(s) _____

Total yearly family income (optional) ____less than \$20,000; ____\$20-40,000;
____\$40-60,000; ____\$60-80,000; ____more than \$80,000

Insurance and Payment Information

All professional services rendered charged to the client. I understand that this office files my insurance as a courtesy but the bill is my responsibility. I am responsible for all fees, including services not covered by insurance, unless expressly noted otherwise. It is customary to pay for services when rendered unless arrangements are made in advance.

Who is financially responsible for the bill:

Name	Address	City, St, Zip (if different)
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_____	_____	_____
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Release of Information

I hereby authorize Triad Counseling and Clinical Services, LLC to release any information necessary to process insurance claims concerning my diagnosis and treatment and I authorize payment of medical/psychological benefits to Triad Counseling and Clinical Services, LLC.

I understand that Triad Counseling and Clinical Services, LLC, is ethically and legal required to report to legal authorities information I give about ongoing abuse of children, disabled and elderly persons and imminent physical danger I present to myself or others because of psychological factors.

I have read, understand and accept the above terms and conditions.

Signature

Date

Triad Counseling and Clinical Services, LLC

806 Green Valley Rd. Suite 301
Greensboro, NC 27408
336-272-8090 Office 336-272-0094 Fax

232 Woodrow Avenue
High Point, NC 27262
336-882-2812 Office 336-882-8632 Fax

Adult Wellness Assessment

Last Name: _____ First Name: _____

Date of Birth: _____ Today's Date: _____

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can. Please check the line that best describes your answer.

How much are you bothered by the following?	<u>Not at all</u>	<u>A little</u>	<u>Somewhat</u>	<u>A lot</u>
1. Nervousness or shakiness	_____	_____	_____	_____
2. Feeling sad	_____	_____	_____	_____
3. Feeling hopeless	_____	_____	_____	_____
4. Feeling everything is an effort	_____	_____	_____	_____
5. Feeling little interest in things	_____	_____	_____	_____
6. Heart pounding or racing	_____	_____	_____	_____
7. Difficulty with sleep	_____	_____	_____	_____
8. Feeling fearful	_____	_____	_____	_____
9. Difficulty at home	_____	_____	_____	_____
10. Difficulty socially	_____	_____	_____	_____
11. Feeling angry or irritable	_____	_____	_____	_____
12. Eating difficulties	_____	_____	_____	_____
13. Difficulty at school or work	_____	_____	_____	_____
14. Sexual Difficulties	_____	_____	_____	_____

If you would like to explain any of the above in greater detail please do so here:

How much do you agree with the following?	<u>Strongly Agree</u>	<u>Agree</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
1. I feel good about myself	_____	_____	_____	_____
2. I can deal with my problems	_____	_____	_____	_____
3. I am able to accomplish the things I want	_____	_____	_____	_____
4. I have friends or family that I can count on for help	_____	_____	_____	_____

Please answer the following questions.

- In general, would you say your health is _____ Excellent _____ Very Good _____ Good _____ Fair _____ Poor
- Please indicate if you have a serious or chronic medical condition. _____
 _____ Asthma _____ Diabetes _____ Heart Disease _____ Back pain or other Chronic Pain _____ Other
- In the past 6 months, how many days were you unable to work because of your physical or mental health?
 (Answer only if employed) _____ Days
- In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? _____ Days
- In the past week, approximately how many drinks of alcohol did you have? _____
- In the past month have you ever felt you ought to cut down on your drinking or drug use? _____yes _____no
- In the past month have you ever felt annoyed by people criticizing your drinking or drug use? _____yes _____no
- In the past month have you felt bad or guilty about your drinking or drug use? _____yes _____no

CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby consent to the use or disclosure of my individually identifiable health information (“protected health information” or PHI), excluding psychotherapy notes, by Triad Counseling and Clinical Services, LLC (Provider) in order to carry out treatment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except in special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my medical/mental health records, although I understand the Provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a “reviewing official.” A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my medical/mental health records, although I understand the Provider has the right to deny such request. I have the right to request an accounting of disclosures of my PHI for purposes other than TOP and those for which I provided authorization. I may submit a written privacy complaint to 806 Green Valley Road, Suite 301, Greensboro, NC 27408 or to the U.S. Secretary of the Department of Health and Human Services, without any action being taken by the Provider against me without any change in my treatment.

Provider reserves the right to change the terms of its Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed, I may obtain a copy of the revised Notice by requesting a copy.

I retain the right to request that the Provider further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Provider is not required to agree to such requested restrictions; however, if the Provider does agree to by requested restriction(s), such restrictions are then binding on the Provider.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Provider in writing. The revocation shall be effective *except* to the extent that the Provider has already taken action in reliance on the Consent.

The Provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the Provider is required by law to treat individuals). If I (or authorized representative) sign the Consent portion and then revoke Consent, the Provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Provider is required by law to treat individuals).

I _____ **CONSENT TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.**

I _____ **DO NOT CONSENT TO THE RELEASE FOR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.**

I _____ **HAVE HAD AN OPPORTUNITY TO REVIEW THE PROVIDER’S NOTICE OF PRIVACY PRACTICES.**

Date: _____

Signature of Patient (or authorized representative)

Please Print Name

Representative’s Authority to act on behalf of the Patient: _____

For Office Use only: Acknowledgement of Privacy Practices was not obtained because:

Professional Disclosure Statement
(Information and Consent)

Dr. Katherine Glenn is pleased that you have selected her as your counselor. The following information is designed to inform you of her background and to ensure your understanding of the nature of the professional therapeutic relationship, your rights as a client, and office policies and procedures.

Dr. Glenn holds a Ph.D. in Counseling and Human Development from the University of North Carolina at Greensboro, her degree having been awarded in 1999. She has been a professional counselor since 1992. She holds the following professional credentials: Licensed Professional Counselor (LPC #704). Licensed Clinical Addictions Specialist (LCAS #650). National Certified Counselor and Masters Addiction Counselor (NCC and MAC #27971),

PROFESSIONAL SERVICES

Dr. Katherine Glenn's services include individual counseling for adults and adolescents. She has training in chemical dependency, co-dependency, compulsive behaviors, grief and loss, trauma-related disorders, developmental transitions, and issues related to sexual orientation. Her therapeutic approach reflects eclectic influences derived from her training in the existential, psychodynamic, family systems, social learning, and cognitive-behavioral theories of counseling. Dr. Glenn views problems as generally being developmental in nature, and approaches each person individually. If for any reason Dr. Glenn does not believe that she has the experience or training necessary to work with your particular difficulty or situation, she will refer you to another mental health professional who is prepared to work more effectively with your presenting concerns.

CONFIDENTIALITY

Dr. Glenn respects your confidentiality. In accord with professional ethics, she may at times consult with peers about aspects of certain cases. She will not reveal your identity in colleague consultations without your written consent. Otherwise Dr. Glenn will only identify you as a client in the following situations: if you have given signed consent for her to discuss your case with another professional or family member, etc.; if you report to her an imminent intent to seriously harm yourself or someone else; or if you reveal to her ongoing physical or sexual abuse or neglect of children, the elderly, or disabled persons. In these latter situations, appropriate persons will be notified.

In rare circumstances, professional counselors can be ordered by a judge to release information. In situations where a client maintains an unpaid balance on their account without having made special arrangements, the account will be turned over to the Credit Bureau, resulting in identification as a client. Otherwise Dr. Glenn will not reveal the fact that you are a client or anything about your treatment, diagnosis, or history.

EXPLANATION OF DUAL RELATIONSHIPS

Although sessions are psychologically intimate, the therapeutic relationship is professional, not social. It is critical that the professional relationship be based on respect, safety, and trust. Therefore, it is in your best interests that contact with Dr. Glenn be limited to counseling sessions or telephone conversations necessary to your therapy.

It is not appropriate for her to relate to you in any way that is outside of the professional context of your therapy. These limits are designed with your welfare in mind and allow for all efforts to be directed towards your concerns.

THERAPIST CANCELLATIONS

Dr. Glenn will try to contact you as quickly as possible should she need to cancel an appointment. Inclement weather or emergencies may necessitate rescheduling, and every attempt will be made to reach you at home or at work to arrange another appointment.

LENGTH OF SESSIONS/MISSED APPOINTMENTS/CANCELLATIONS

Services will be rendered in a professional manner consistent with accepted ethical standards. Sessions are 45-50 minutes in duration and will be scheduled at mutually agreed upon times. If you must cancel your appointment, please do so promptly so that the appointment time may be given to someone else. There is no charge for sessions cancelled at least twenty-four (24) hours in advance. For a cancellation made within twenty-four hours of the appointment, you may be charged. **FOR A MISSED APPOINTMENT WHICH IS NOT CANCELLED, A FULL CHARGE IS MADE. Insurance companies do not reimburse missed appointments. If no one is available to take your call, please leave a message at 336-272-8090 on our 24 hour voice mail.**

THERAPIST VACATIONS/CLIENT EMERGENCIES

Dr. Glenn will try to inform you of her vacations at least one week in advance. When she is out of town or otherwise unavailable, Ms. Ball, Ms. Dowda, or Ms. Elliott will help with client emergencies. Call the office, 336-272-8090, to reach one of these therapists. If you have a severe crisis and are unable to contact a therapist, please call High Point Behavioral Health (1-800-525-9375), Moses Cone Behavioral Health at (1-800-525-9375), or the Guilford County Emergency number (911). If you are outside of Guilford County, please call the emergency numbers of the county where you are.

FEES/METHODS OF PAYMENT

Fees for professional services are due at the time of each session. The fee for the initial diagnostic interview is \$170.00. Standard fee for each subsequent session is \$140.00 per 45-50 minute session. Cash, personal checks and Visa or Master Card are acceptable for payment. You will be mailed a monthly statement as a receipt unless you request otherwise.

INSURANCE

Our office will file insurance claims on your behalf. If you have a deductible it is our policy to collect the entire fee for the initial session and any subsequent sessions until your deductible has been met. However you may pay your portion of the fee thereafter. If your insurance benefits state that you are responsible for a set co-pay or co-insurance, you will only be required to pay that amount on the date services are rendered. If you prefer to file for insurance reimbursements to be paid to you instead, you will need to pay the full fee at the time the services are rendered. Should your insurance program have special arrangement, please discuss this with our Insurance Coordinator.

Be aware that filing for insurance requires a diagnostic statement to be placed in your permanent insurance records. The forms must be signed by you in order to authorize the release of confidential information. If you wish to be informed of the diagnosis before it is submitted to your health insurance company, please make Dr. Glenn aware of this, and she will discuss the diagnosis fully with you.

Please remember that Dr. Glenn's professional services are rendered to you, not to the insurance company. In accepting Dr. Glenn's services you also accept the responsibility of paying for these services should your insurance company pay only a part of the fee or deny the claim altogether. A minimum of 50% co-pay is expected at the time of service if the co-payment is not known.

OVERDUE ACCOUNTS

All accounts become overdue after thirty (30) days if no payment or arrangements have been made. Dr. Glenn will make every effort to cooperate with any individual who has special financial concerns. Please discuss this matter with Dr. Glenn because past due accounts may be turned over to the Credit Bureau for processing if no special arrangements are made.

OFFICE STAFF

Samantha Dabbs is the Insurance and Collections Coordinator for Triad Counseling and Clinical Services, LLC. Her office hours are 8:30am-4:30pm Monday through Thursday and 8:30 – 12:30 on Fridays. Carol Gillespie is the Office Receptionist for Triad Counseling and Clinical Services, LLC. Her office hours are 11:00 – 4:00 Monday through Thursday and 9:00 –12:00 on Fridays. Inquiries about accounts and insurance should be directed to either member of the staff, should you have a concern.

SMOKING/USE OF MIND ALTERING DRUGS OR ALCOHOL

No smoking is allowed in the building. Do not appear for a session under the influence of any mind-altering drug, including alcohol. Should this situation occur, the therapy session will not take place and you will be charged in full for the session. Such an occurrence may be considered grounds for the termination of therapy.

COMPLAINT PROCEDURES

If you are dissatisfied with any aspect of your counseling with Dr. Glenn, please inform her immediately. If you think that you have been treated unethically, by Dr. Glenn or any other counselor, and you have been unable to resolve the problem with Dr. Glenn, you can contact the North Carolina Board of Licensed Professional Counselors at P.O. Box 1369, Garner, NC 27529-1369, or (919-661-0820) for clarification of client rights or to lodge a complaint.

If you have any questions, please discuss them with Dr. Glenn. To indicate that you have read and understand the information presented to you, please sign and date this form. A copy for your record will be returned to you, and one will be kept by this office in your confidential records.

Katherine H. Glenn, Ph.D., LPC, LCAS

Client's Signature (or Parent/Guardian, if minor)

Date

Date

I have received a copy of Patient Right & Responsibilities which is located on the back of this statement.

PATIENTS RIGHTS & RESPONSIBILITIES

- Patients have the right to be treated with personal dignity and respect.
- Patients have the right to care that is considerate and respects member's personal values and belief system.
- Patients have the right to personal privacy and confidentiality of information.
- Patients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and patient rights and responsibilities.
- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Patients have the right to participate in an informed way in the decision making process regarding their treatment planning.
- Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.
- Patients have the right to individualized treatment, including
 - Adequate and humane services regardless of the source (s) of financial support,
 - Provision of services within the least restrictive environment possible,
 - An individualized treatment or program plan,
 - Periodic review of the treatment or program plan,
 - An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.
- Patients have the right to participate in the consideration of ethical issues that arise in the Provision of care and services, including
 - Resolving conflict,
 - Withholding resuscitative services,
 - Forgoing or withdrawing life-sustaining treatment, and
 - Participating in investigational studies or clinical trials.
- Patients have the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Patients and their families have the right to be informed of their rights in a language they understand.
- Patients have the right to voice complaints or appeals about managed care company or the care provider.
- Patients have the right to make recommendations regarding managed care company rights and responsibilities policies.
- Patients have the right to be informed of rules and regulations concerning patients' conduct.
- Patients have the responsibility to give their provider and managed care company information needed in order to receive care.
- Patients have the responsibility to follow their agreed upon treatment plan and instructions for care.
- Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with their provider mutually agreed upon treatment goals.