

## 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:

1<sup>st</sup> from \_\_\_\_\_ to \_\_\_\_\_ 2<sup>nd</sup> from \_\_\_\_\_ to \_\_\_\_\_

3<sup>rd</sup> from \_\_\_\_\_ to \_\_\_\_\_ 4<sup>th</sup> 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 1<sup>st</sup> 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

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### 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

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# 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:

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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)

Nancy Conrad Ball 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.

Ms. Ball holds a Master of Education degree in mental health counseling from the University of North Carolina at Greensboro, her degree having been awarded in 1992. She is a Licensed Professional Counselor (LPC #769) and a National Certified Counselor (NCC #27975). She was the recipient of the UNC-G Department of Counseling and Development Distinguished Practitioner award in 1996 and the Chi Sigma Iota Counseling Academic and Professional Honor Society Outstanding Practitioner award in 1998.

**PROFESSIONAL SERVICES**

Nancy Conrad Ball's services include individual, couples, family & group counseling for adults & adolescents. She was previously employed by Psychological Services of the Triad for 3 ½ years and completed her internship at Urban Ministry of Greensboro. Her therapeutic approach reflects eclectic influences derived from her training in existential, psychodynamic, strategic, family systems, reality, developmental & cognitive-behavioral theories of counseling. Her special interests include relationship concerns, marital problems, separation, divorce, child custody mediation, stepfamily issues, communication, anxiety, depression, victimization, women's issues, developmental transitions of adulthood, and grief counseling. If for any reason Ms. Ball 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 that is prepared to work more effectively with your presenting concern.

**CONFIDENTIALITY**

Ms. Ball respects your confidentiality. In accord with professional ethics and HIPAA (Federal Compliance Regulations), a minimum amount of necessary information about you will be released for treatment, payment and healthcare operations. She may at times consult with peers about aspects of certain cases.

Ms. Ball 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 intention 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 their account may be turned over to the Credit Bureau, resulting in their identification as a client. Otherwise, Ms. Ball 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 Ms. Ball be limited to counseling sessions or telephone conversations necessary to your therapy. It is not appropriate to extend social invitations or gifts to Ms. Ball or to ask her to relate to you in any other 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**

Ms. Ball will try to contact you as quickly as possible should she need to cancel an appointment.

## **LENGTH OF SESSIONS/MISSED APPOINTMENTS/CANCELLATIONS**

Services will be rendered in a professional manner consistent with accepted ethical standards. Sessions are forty-five (45) to fifty (50) minutes in duration and will be scheduled at mutually agreed upon times. If you must cancel your appointment, please do so promptly so 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, you may leave a message 24 hours a day at 336-272-8090.**

## **THERAPIST VACATIONS/CLIENT EMERGENCIES**

Ms. Ball will try to inform you of her vacations at least one week in advance. When she is out of town or otherwise unavailable, Ms. Dowda, Ms. Elliott or Ms. Glenn 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 Moses Cone Behavioral Health at (800) 711-2635 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**

The fee for professional services is due when the service is rendered. The initial fee for individual psychotherapy is \$150.00. Standard fee for individual therapy is \$125.00 per fifty minute session. Cash, personal checks, MasterCard or Visa are acceptable for payment.

## **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 you prefer to file for insurance reimbursements to be paid to you instead, you will need to pay the full fee at the time that services are rendered. Should your insurance program have special arrangements, please discuss these with our office manager.

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 Ms. Ball aware of this, and she will discuss the diagnosis fully with you.

Please remember that Ms. Ball's professional services are rendered to you, not to the insurance company. In accepting Ms. Ball'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% copy is expected at 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. Ms. Ball will make every effort to cooperate with any individual who has special financial concerns. Please discuss this matter with Ms. Ball because past due accounts may be turned over to the Credit Bureau for processing if no special arrangements are made.

**OFFICE STAFF HOURS**

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

**COMPLAINT PROCEDURES**

If you are dissatisfied with any aspect of your counseling experience with Ms. Ball, please inform her immediately. If you think that you have been treated unfairly or unethically, by Ms. Ball or any other counselor, and you have not been able to resolve the problem with Ms. Ball, you can contact The North Carolina Board of Licensed Professional Counselors at P.O. Box 1369, Garner, NC, 27529-1369, (919) 661-0820 for clarification of client rights or to lodge a complaint.

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

\_\_\_\_\_  
Nancy C. Ball, M.Ed., LPC, NCC

\_\_\_\_\_  
Client’s signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

I have received a copy of Patients Rights and Responsibilities which is located on the back of this Disclosure 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.