

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

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)

Name of Insurance Policy Holder Social Security of Policy Holder Date of Birth

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.

Date Signature

Triad Counseling and Clinical Services, LLC
806 Green Valley Rd. Suite 301 Greensboro, NC 27408 and 232 Woodrow Ave High Point, NC 27262

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:

CONSENT FOR RELEASE OF MENTAL HEALTH INFORMATION

This form is used to be able to discuss or release information to you (or your child's) primary care doctor only, in order to coordinate treatment.

If you wish for information to be release to the primary care doctor only, please fill in the name of that doctor, check by the authorization line and sign and date the form.

If you DO NOT wish for information to be released to the primary care doctor, check by the decline line and sign and date the form.

Patient Name: _____ Date of Birth: ___mo ___day ___year

Mental Health Provider Name: _____

Primary Care Physician Name: _____

Primary Care Physician Address: _____
Street City, State

Primary Care Physician Phone: _____

____ I authorize the release of relevant treatment information to the provider named above. I understand that these records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. My consent may be revoked at any time, and expires one year from the date signed.

____ I decline the release of treatment information to my Primary Care Physician.

Signature of Patient or Legal Guardian

Date

Relationship to Patient

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 anxious or worried	_____	_____	_____	_____
5. Feeling everything is an effort	_____	_____	_____	_____
6. Feeling little interest in things	_____	_____	_____	_____
7. Heart pounding or racing	_____	_____	_____	_____
8. Difficulty with sleep	_____	_____	_____	_____
9. Feeling fearful	_____	_____	_____	_____
10. Difficulty at home	_____	_____	_____	_____
11. Difficulty socially	_____	_____	_____	_____
12. Feeling angry or irritable	_____	_____	_____	_____
13. Eating difficulties	_____	_____	_____	_____
14. Difficulty at school or work	_____	_____	_____	_____
15. 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

Traci Pulliam Collins, M.S., LPCA, NCC

806 Green Valley, Suite 301

Greensboro, NC 27408

Office: 336-272-8090

Professional Disclosure Statement

Hello and Welcome! I appreciate your consideration in creating a therapeutic relationship. Please read through the following document in an effort to achieve mutual understanding and expectations about the provided counseling services. I will be happy to clarify information or answer concerns at any time throughout the duration of the counseling relationship, and thereafter.

Qualifications, Experience, and Interests

In 2011, I received a master's degree in clinical mental health counseling from the University North Carolina at Greensboro. I am licensed as a Licensed Professional Counselor Associate [LPCA #A8880] approved by the North Carolina Board of Licensed Professional Counselors [NCBLPC]. Also, I am certified as a National Certified Counselor [NCC #283517] by the National Board for Certified Counselors. During my master's program, I provided individual and group counseling services to college students and adult community members for approximately a year and a half. I have also completed additional training in family therapy, couples therapy, and women's issues.

My special interests include marriage counseling, couples counseling, family counseling, relationship concerns, parenting concerns, women's issues, developmental transitions, adjustment disorders, depression, anxiety, spirituality, career issues, and communication, intimacy, attachment, and self-esteem difficulties. If I do not believe that I have the experience or training necessary to work with your particular situation, I will refer you to another to mental health professional that can more effectively work with your concerns or difficulties.

Counseling Services

Overall, it is always my goal to create a safe, accepting, and comfortable environment, which is conducive to allow you, the client, to grow in self-awareness and self-acceptance. Initially, it is my goal that we work together to form a mutually desirable relationship and focus our counseling sessions by setting goals, which we will continue to assess throughout the counseling process. My general counseling approach is Cognitive-Behavioral Therapy and Emotionally Focused Therapy. However, I have a great interest and draw many techniques from other theoretical approaches.

As a counselor, I am unable to prescribe medication. In the event that a referral is necessary, a medical doctor or nurse practitioner will appropriately evaluate the situation and make their suggestions for treatment. A diagnosis is a description of a pattern of behaviors. It is important to be aware that a diagnosis does become part of your permanent record.

Session Description/Missed Appointment or Cancellations

Sessions are scheduled to be 45-50 minutes in duration. In order to stay focused and progress towards the decided goals, it is important to establish regularity among the counseling process. Certainly, situations will arise that disallow sessions to occur. However, it is my goal that the counseling sessions do began and end on time. Please give a 24-hour notice for the cancelation of an appointment. If I do not receive notice of cancelation at least 24-hours before the scheduled appointment, you may be responsible for the full price of the missed session. FOR A MISSED APPOINTMENT THAT IS NOT CANCELLED, A FULL CHARGE IS MADE. If no one is available to take your call, you may leave a message 24 hours a day at 336-272-8090. A recurring problem with cancelations or missed appointments may result in termination of services.

Please do not appear for a session under the influence of alcohol or any mind-altering drug. If this occurs the session will be cancelled and you will be charged for the missed session, and ultimately termination of the counseling relationship may occur.

Therapist Vacations or Cancellations/ Client Emergencies

In the event that I may need to cancel an appointment, I will try to contact you as quickly as possible. Inclement weather or emergencies may require rescheduling. I will make every attempt possible to contact you at home, work, or on your cell phone to arrange another appointment.

I will inform you of scheduled vacations at least 1 week in advance. During this time or when I am otherwise unavailable, you may leave a message for me at the office (336-272-8090). If you are having an emergency or severe crisis and are unable to reach me, please call Moses Cone Behavioral Health (1-800-525-9375) or High Point Behavioral Health (1-800-525-9375). Also, you may call the Guilford County Emergency number (911). If you are outside of Guilford County, please call the emergency number for the county where you are or call (911).

Payments and Fees

The fee for an intake session is \$90. The fee for a standard 50-minute session is \$75. I accept cash, check, and credit card payments, but I do not bill health insurance companies for services at this time. When I am able to bill for health insurance services, I will let you know of that change and the payment arrangements will be reassessed at that time. Please note that a recurring problem with missed appointments and/or nonpayment for services may result in termination of services.

I understand that there may be a time where you need to call me between sessions. It is important to note that phone calls are not charged unless they exceed 15 minutes. If your call is more than 15 minutes or a combination of calls is more than 15 minutes, you will be charged on a prorated basis relative to the hourly fee originally agreed upon. If I am summoned to court on your behalf, you are responsible to pay the agreed upon hourly rate for any associated time and efforts. This includes, but is not limited to, time spent in transcribing records, time in court, travel, meals, and any wait time preceding the actual court appearance.

Overdue Accounts

I will make every effort to cooperate and make arrangements with any individual seeking counseling services that has financial concerns. However, if no payment has been made or any special arrangements set in place, all accounts become overdue after thirty (30) days. If you maintain an unpaid balance on your account without making special arrangements, the account will be turned over to the Credit Bureau. This will result your identification as a client.

Explanation of Dual Relationships

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social relationship. Therefore, our contact will be limited to the sessions you arrange with me, so please do not invite me to social gatherings, offer me gifts, or ask me to relate to you in any other way than a professional context of our counseling sessions. It is in your best interest if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. During the counseling experience, you will learn a great deal about me as we work together, however, it is important for you to remember that you are experiencing me in my professional role. If we encounter one another outside of the counseling sessions, I will not approach you in order to protect your confidentiality. Please understand that it is in your best interest as a client that our contact be limited to strictly a professional relationship.

Confidentiality

As a counselor, I abide by the standards of confidentiality set forth by the NCBLPC, and upheld by the state law. Therefore, the information spoken, written, or disclosed in any matter throughout the duration of our counseling relationship and anytime thereafter will be held confidential. However, there are several situations in which I cannot legally or ethically hold the information confidential, such as:

- 1.If you disclose directly or it is reasonably suspected that you will pose imminent danger to the health and safety of yourself or others;
- 2.If at anytime you disclose that a child or elder adult has been or will be abused or neglected;
- 3.In the event that a court order requires the release of case records or direct testimony;
- 4.If you request that your records be released, and sign a release of information form;
- 5.If you are a minor, your confidentiality is constrained by the request of your parent and/or legal guardian.

Once again, the information disclosed throughout the counseling process will be held confidential according to license and state law. It is important to be aware that, at times, I may participate in supervision/consultation with other licensed professions, so that I may receive feedback about treatment strategies in order to be most effective as your counselor. I will not reveal your identity without your express written consent. Also, in a counseling setting with multiple clients, such as group, family, or couples counseling, it is important to note that I can only guarantee my own assurance to uphold confidentiality as described above.

Termination

It is my hope that the counseling sessions will lead you to a more desirable place and that you will experience improvement regarding your reasons for seeking counseling services. Every situation is unique and it is impossible to determine the exact course and length of the counseling sessions. However, throughout the counseling process, the goals for therapy will be reassessed. At the appropriate time, termination will be discussed.

It is important to know that you may choose to terminate services at any time. If you decide to discontinue therapy abruptly and without notice, I will call you no more than two times to follow up with you within two weeks following our last session. If you do not return my calls, your file will be closed and it will be noted that you terminated therapy with me without notice or consultation.

Complaints

My goal is to establish a nurturing relationship with all clients, and certainly I would want to know if that was not being achieved. If you are unhappy with any aspect of the provided counseling services please feel encouraged to discuss this with me. If you feel that your concern has not been resolved after communicating that concern to me, you may contact and voice your concern to my supervisor Dr. Katherine Glenn at (336) 272-8090. You may also contact the North Carolina Board of Licensed Professional Counselors, PO Box 1369, Garner, NC 27529, Phone: 919.661.0820

I look forward to working together in a counseling relationship. If you have any questions regarding the information in this document or any other part of the counseling process, please feel free to let me know.

Traci Pulliam Collins, M.S., LPCA, NCC**Date** _____

Client's Signature (Parent/Guardian)**Date** _____