

Client Data Sheet (Adult)**Please Print**

Date: _____ Referred by: _____

Name: (as listed on your 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)

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

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: _____

Sara DeHart Young, MS, LPC, ATR, NCC
Masters of Science in Art Therapy (EVMS, 1993)
Licensed Professional Counselor, North Carolina (License # 7310)
Nationally Certified Counselor (NCC # 37290)
Art Therapist, Registered (ATR# 00-007)

PROFESSIONAL DISCLOSURE STATEMENT

~Information and Consent~

Thank you for choosing me as your counselor. I am pleased to have this opportunity to work with you and/or your family so that you may be able to feel greater fulfillment in the areas of your life that are currently causing you distress. This document is designed to inform you about my background, our professional relationship, your rights as a client, and policies and procedures. I encourage you to voice any expectations and/or concerns that you may have at any time while we're working together. An important factor in the success of the therapeutic process is open communication, so please do not hesitate to ask. As a therapist I have documented expertise in mental health treatment, but please remember that your feedback, input and opinions are very important to me. Please feel free to share your honest reactions about treatment with me. If you believe that therapy is not proving helpful, you have the right to terminate services. You also have the right to, and I am happy to provide, a list of referrals to other treatment providers.

I hold a Masters of Science (MS) degree in Art Therapy from Eastern Virginia Medical School (EVMS), which was awarded to me in 1993. I have been a practicing counselor since 1993 and have been a Nationally Certified Counselor (NCC #37290) since 1995, a Registered Art Therapist (ATR # 00-007) since 2000, a Licensed Professional Counselor in the state of Mississippi (LPC # 1021) from 2003-2009, and a Licensed Professional Counselor in North Carolina (LPC # 7310) since March of 2009.

The Therapeutic Process

Therapy is a process of solving emotional problems with a person professionally trained to help you achieve the clarity, insight and problem-solving skills you need to attain a more fulfilling life. This process of change will in many ways be unique to your particular situation. It is very important that we establish clear goals within the first several sessions so that we can see your progress. We will try to review these goals regularly. It is important to note that working towards these goals is a collaborative process. It is my belief that as a therapist I am here to support, encourage and suggest ways in which you can successfully reach your goals, however you are the only one who can actually make the changes that will necessarily be part of achieving greater emotional health. It is important for you to know that sometimes participation in psychotherapy involves the exacerbation of symptoms, however, over time, you should see improvement. It is my sincere goal to help you/your family meet your goals as quickly as possible. For some clients this will only require that we meet a few times. Others may require more long-term involvement. Your active participation in the therapy process is necessary for progress to be made and sessions may occur weekly, biweekly or monthly. Your promptness for these sessions will allow you to take full advantage of these appointments.

Professional Services

My services include individual, couples, family and group counseling with adults, adolescents and children. My training in individual, couples and family counseling is in the areas of anxiety and depressive disorders, eating disorders, co-dependency and other relationship issues, victimization/trauma issues (esp. physical and sexual abuse), grief and loss issues and developmental transitions. My therapeutic approach reflects eclectic influences derived from my training in the psychodynamic, family systems, cognitive-behavioral, and Gestalt theories of counseling, as well as the incorporation of evidenced-based Art Therapy and play therapy techniques as appropriate. I view problems as generally being developmental in nature, and approach each person, couple, family or group in a unique fashion. If for any reason I do not believe I have the experience or training necessary to work with your particular situation, I will refer you to another mental health professional that is prepared to work more effectively with your presenting concerns.

Confidentiality

Protecting your confidentiality is very important to me. Your case records will remain safely locked at all times and will not be disclosed to anyone, including another professional or family member, without your express written consent.

As your therapist I will not disclose confidential information about you or your family to anyone else except in the following situations:

- Abuse of Children or Elderly Persons: If a mental health professional reasonably believes that a child under the age of 18 or an elderly person is being abused or neglected, s/he is legally obligated to report this situation to the appropriate state agency.
- Imminent Harm to Self: If a mental health professional reasonably believes that you are in imminent danger of physically harming yourself (including significant alcohol and/or drug abuse) and if you are unwilling or unable to follow treatment recommendations, s/he may have to make an involuntary referral to a hospital and/or contact a family member or other person who may be able to help protect you.
- Imminent Harm to Others: If a mental health professional reasonably believes that you are seriously threatening physical violence against another person, or if you have a history of physically violent behavior, and if s/he believes you are an actual threat to the safety of another person, s/he may be required to take some action (such as contacting the police, notifying the other person, seeking involuntary hospitalization, or some combination of these actions).
- Peer Supervision: In order that I may provide you with the best services possible, and in accordance with professional ethics, I may, at times, participate in peer supervision/consultation with other Licensed Professional Counselors (LPC's) so that I may receive feedback about treatment strategies and other ways in which I may be most effective as your counselor. Please note that even in these colleague consultations I will not reveal your identity without your express written consent.
- Court Order: In rare circumstances Professional Counselors can be ordered by a judge to release information regarding treatment, diagnosis and history.
- 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.

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 interest that contact with me be limited to counseling sessions or telephone conversations necessary to your therapy. It is not appropriate to extend social invitations or gifts to me or ask me to relate to you in any other way outside the professional context of our therapy. These limits are designed with your welfare in mind and allow for all efforts to be directed toward your therapeutic concerns only. In addition, because we often live in the same community, if I see you in a public setting, I will not acknowledge you unless you first acknowledge me. I think it is best that any public discussion be kept to polite interactions. Please do not take offense and know that this policy is an extension of my respect for you and my desire to protect your confidentiality and preserve the integrity of our therapeutic relationship.

Length of Sessions/Missed Appointments and Cancellations

Services will be provided 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 your appointment time may be given to someone else. There is no charge for cancellations at least twenty-four (24) hours in advance. For a cancellation made within 24 hours of the appointment, you may be charged. **FOR A MISSED APPOINTMENT THAT IS NOT CANCELED, A FULL CHARGE IS MADE.** Insurance companies do not reimburse for missed appointments. If no one is available at 336-272-8090 to take your call please leave a message on our 24 hours voice mail. A recurring problem with “no shows” and/or nonpayment for services may result in termination of services.

Therapist Cancellations/Vacations/Client Emergencies

Ms. Young will try make every effort to inform you of the necessity to cancel an appointment as quickly as possible. Inclement weather, illness or other emergency may necessitate rescheduling and every effort will be made as soon as possible at home or work to arrange another appointment.

Ms. Young will inform you at least 1 week in advance of scheduled vacations. When she is out of town or otherwise unavailable, you may leave a message for me at 336-501-5805 (cell) or 336-272-8090 (office). If you have a severe crisis and are unable to contact me, please call the Guilford Center for Behavioral Health and Disability Services at 800-853-5163 (during business hours), 336-641-4993 (after hours), High Point Behavioral Health (1-800-525-9375), Moses Cone Behavioral Health (1-800-525-9375) or the Guilford County Emergency number (911). If you are outside of Guilford County, please call the emergency number for the county where you are.

Fees

Fees for professional services are dues at the time of each session. The fee for an initial diagnostic interview is **\$150.00**. Standard fee for each subsequent session is **\$120.00** per 45-50 minute session. Cash, personal checks, and Visa or Master Card are acceptable forms of payment. You will be mailed a monthly statement as a receipt unless you request otherwise.

If I am summoned to court on your behalf you are responsible for paying my hourly fee for any time spent in transcribing records requested by you, time in court, including, but not limited to, travel, meals, and any wait time prior to actual court appearance.

Insurance

Triad Counseling and Clinical Services, LLC will file insurance claims on your behalf. If you have a deductible it is our policy to collect the entire fee for the session and any subsequent sessions until your deductible has been met. However, once the deductible is met you are only responsible for 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. Should your insurance program have special arrangements, please discuss this with our Insurance Coordinator.

Please remember that Ms. Young's professional services are rendered to you, not the insurance company. In accepting my 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.

When insurance is utilized for therapy services, clients should be aware of the limits of confidentiality and the fact that filing for insurance necessarily requires a diagnostic statement to be placed in your 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. Young aware of this, and she will discuss the diagnosis fully with you. Typically, insurance companies require the following information: diagnosis, dates of service, the kind of service you received (i.e. individual, group, family, etc.), and the name of the client. Some managed care companies require additional information. Thus, you may not have the extent of confidentiality that you might otherwise expect. Signing this agreement authorizes the release of information to your insurance company.

Overdue Accounts

All accounts become overdue after thirty (30) days if no payment or arrangements have been made. Ms. Young will make every effort to cooperate with any individual who has special financial concerns. Please discuss this matter with Ms. Young 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-Thursday and 8:30pm-12:30pm on Fridays. Carol Gillespie is the Office receptionist for Triad Counseling and Clinical Services, LLC. Her office hours are 11:00am-4:00pm Monday-Thursday and 9:00am-12:00pm on Fridays. Inquiries about accounts and insurance should be directed to either member of the staff, should you have a concern.

Use of Mind-altering Drugs or Alcohol

No smoking is allowed in the building. Please do not appear for a session under the influence of any mind-altering drug, including alcohol. Should the 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 with Ms. Young, please inform her immediately. If you think you have been treated unfairly or unethically, by Ms. Young or any other counselor, and you have been unable to resolve the problem with Ms. Young, you can contact the North Carolina Board of Licensed Professional Counselors at PO 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 Ms. Young. To indicate that you have read and understand the information presented to you, please sign and date the form. A copy for your record will be returned to you, and one will be kept by this office in your confidential records.

Sara DeHart Young, MS, LPC, ATR, NCC

Date

Client's signature (or parent/guardian if minor)

Date

I have received a copy of Patient Rights & 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.