

PATIENT PROFILE: School Based Therapy

DATE:_____ (Office Use Only: Provider):_____

NAME:_____

FIRST

MIDDLE INITIAL

LAST

ADDRESS:_____

CITY

STATE

ZIP

COUNTY_____DATE OF BIRTH_____AGE_____SSN#_____

MARITAL STATUS_____DRIVER'S LICENSE #_____

HOME PHONE_____WORK /CELL PHONE_____

LEGAL GUARDIAN/RELATIONSHIP_____

EMPLOYER OR SCHOOL ATTENDING/GRADE_____

EMERGENCY CONTACT/TELEPHONE_____

PRIMARY PHYSICIAN/TELEPHONE_____

CURRENT MEDICATIONS_____

ALLERGIES_____

NATURE OF CONCERN REQUIRING COUNSELING_____

INSURANCE INFORMATION

TYPE OF INSURANCE: Medicaid ☐

Private Insurance ☐

Non-insured ☐

1 OF 4 INFORMED CONSENT (Patient/Guardian: keep pages 1-3. Office retains page 4.)

TIME COMMITMENT: Today's appointment will take approximately 1 hour. We realize that starting counseling is a major decision and you may have many questions. This document, along with the HIPPA Information form, strives to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

EMERGENCIES: If an emergency situation for which the client or their guardian feels immediate attention is necessary, please contact your counselor via their cell phone number. However, if your counselor is unavailable, you may call the office number to obtain contact info for Jodi or Kenneth Province. If no contact can be made the client or guardian understands that they are to contact 911 or visit a local emergency room for services as a last resort, or contact Smoky Mountain Center at 1-800-849-6127 or Partners MCO 1-888-235-HOPE, Cardinal Innovations MCO (704) 939-7700, or mobile crisis at 877-492-2785 or 336-838-9936. This agency will follow those emergency services with standard counseling and support to the client or the client's family. For any grievance you may also contact the above MCO for your covered region. If you have any grievance you may call the number above.

RISKS AND BENEFITS: Please note there are risks and benefits to counseling. These will be discussed with you today as it relates to your case specifically. Alternative methods to treatment will also be discussed today. Each licensure board has a grievance process or system. If you wish to make a grievance, please contact the appropriate licensure board to file a complaint.

CONFIDENTIALITY: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or your child or children report about physical or sexual abuse; then, by North Carolina State Law, your counselor is obligated to report this to the Department of Social Services, as well as any report that c) you the client have an infectious disease that you will intentionally spread to harm others d) where you sign a release of information to have specific information shared and e) if you provide information that informs your counselor that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and g) or when required by law.

APPOINTMENTS, PROFESSIONAL FEES, AND CANCELLATIONS: Appointments are generally 45 to 60 minutes in length. Initial intakes are \$160.00, Counseling sessions are \$140.00, *Psychological testing fees are dependent on the amount of time involved and are billed per hour. Because they vary we will discuss fees with you in advance. Other services including report writing, telephone conversations longer than 10 minutes, attendance and meetings with other professionals, court appearances/involvement, etc. can be charged at hourly rates. A \$100 up-front fee is charged for any court appearances. Letter/report fees: \$45.

As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your account has not been paid for 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment.

This may involve but not be limited to hiring a collection agency or going through small claims court. If that were necessary you will be responsible for all cost of litigation including attorney's fees. In most collection situations the only information released would be the client's name and address, nature of services provided, and the amount due. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You should also be aware that most insurances companies require you to authorize us to provide them with confidential information such as clinical diagnoses, treatment plans/summaries, or copies of records. This information becomes part of the insurance company's files. All insurance companies claim to keep such information confidential, however we have no control over this information once received by the insurance companies.

It is important to remember that you may always pay for services yourself to avoid the potential problems described above.

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Private Practice Social Media Policy:

By signing below you acknowledge that we may contact you at the numbers you provided on your patient profile. This also allows us to leave you a message at these numbers from our office. You also consent to allow us to contact you via your email.

This section outlines our office policies related to use of Social Media. Please read it to understand how we conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, we encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when we need to update this policy. If so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending: We do not accept friend or contact requests from current or former clients on any social networking site (Facebook,

LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Fanning: As of May 2015, we have deleted our professional Facebook Page after concluding that the potential risks of maintaining such a Page outweigh any potential gains. Some therapists keep a Facebook Page for their private or professional use. They may allow people to share their blog posts and practice updates with other Facebook users. You are welcome to view www.jodiprovincecs.com. However, in regards to blogs or post, we do not accept clients as Fans of this Page. We believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list. In addition, the American Psychological Association's Ethics Code prohibits my soliciting testimonials from clients.

We feel that the term "Fan" comes too close to an implied request for a public endorsement of this practice.

Following: If we publish a blog on our website or any other social media and if you use an easily recognizable name on Twitter (for example) and we happen to notice that you've followed us there, we may briefly discuss it and its potential impact on our working relationship. Our primary concern is your privacy. If you share this concern, there are more private ways to follow us on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate your having a public link to a therapist's content. Note, we will not follow you back.

In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Interacting: Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact us. These sites are not secure and we will not read these messages. Do not use Wall postings, @replies, or other means of engaging with us in public online if we have an already established client/therapist relationship. Engaging with us this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact us between sessions, the best way to do so is by phone. 336-818-0733 or 336-526-0073 for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

Use of Search Engines It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with us via our usual means, coming to appointments, phone, or email (if consented to), there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations

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and if we ever resort to such means, we will fully document it and discuss it with you when we next meet.

Google Reader: We do not follow current or former clients on Google Reader and we do not use Google Reader to share articles. If there are things you want to share with us that you feel is relevant to your treatment whether they are news items or things you have created, we encourage you to bring these items of interest into our sessions.

Business Review Sites: You may find our counseling practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of Social Media Policy whether the business has added itself to the site. If you should find our listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative.

We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with us about your feelings about our work, there is a good possibility that we may never see it. If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide you and your counselor or clinician are not a good fit. None of this is meant to keep you from sharing that you are in therapy wherever and with whomever you like. Confidentiality means that we cannot tell people that you are a client and we will follow our Ethics Code. But you are more than welcome to tell anyone you wish about your therapy or how you feel about the treatment, in any forum of your choosing. If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection. If you feel we have done something harmful or unethical and you do not feel comfortable discussing it with your counselor, you can always contact the Board of Counseling for NC, which oversees licensing, and they will review the services we have provided. P.O. Box 77819, Greensboro, NC 27417.

Email: By signing our informed consent, you acknowledge and are giving us permission to email you regarding any need in your counseling as an active or inactive/closed client. You are acknowledging that email is not completely secure or confidential. If you choose to communicate with us by email, be aware that all emails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails we receive from you and any responses that we send to you become a part of your legal record.

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to your clinician's attention so that we can discuss them.

By signing below, you also acknowledge receipt of our ""Client Rights and HIPAA Information". We are happy to provide you a copy at your request, or you may review these at www.jodiprovinceccs.com.

SCHEDULED APPOINTMENTS: Please be respectful of our time. If you must reschedule or cancel, please phone 24 hours in advance in order not to be charged for the session. A pattern of missed appointments will lead to additional charges that are not covered by insurance and may result in an end to treatment. Three no-shows (or failure to cancel without 24 hours notice) will result in termination of services at the discretion of your counselor. By signing our informed consent you acknowledge the following: Non-Medicaid clients can be charged \$50 for sessions missed or cancelled with less than 24 hours notice. These fees are not covered by insurance and payment will be required prior to any further services being provided. All clients with three no-shows/failure to cancel within 24 hours can be terminated with this agency.

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Acknowledgement of Informed Consent:

Signature of client or guardian

Date

Signature of Clinician

Date

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that _____ (minor's name) may be treated as a client at Jodi Province Counseling Services, PLLC. Please be aware that the law may provide parents/guardians the right to examine treatment records. It is our policy to provide parents/guardians access to information about treatment. However we also ask parents/guardians to trust us and allow us to keep your confidences on specific information and we will provide them with general information about your treatment sessions. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children.

Signature of client or guardian

Date

To be reviewed with therapist:

I have reviewed and been given a copy, at my request, of my therapist's Professional Disclosure Statement. I understand the information provided to me.

Client and/or Guardian Signature: _____ Date _____

Counselor's Signature: _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION: Doctor

I (We) authorize Jodi Province Counseling Services, PLLC to release and disclose information from the clinical record of: _____

Name of client/recipient of mental health services

Date of birth

to, and allow such information to be inspected and copied by: _____

Facility/Provider/Address

Nature of information to be disclosed: _____

State specific nature of information to be disclosed

For the purposes of _____

State specific purpose of information to be disclosed

Information to be released and/or exchanged includes any available substance use/abuse or HIV/Infectious disease information as verified by client initials: yes _____ no _____

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Jodi Province Counseling Services, PLLC office. I understand that a revocation is not valid to the extent that Jodi Province Counseling Services, PLLC office has acted in reliance on such authorization. This authorization is valid until _____. (Date)

A copy of this release shall have the same force and effect as the original. By signing below I acknowledge that I have been notified that release/disclosure of information may only occur with a consent unless it is an emergency or for other exceptions as detailed in the General Statutes or in 45 CFR 164.512 of HIPAA.

Client Signature 12 yrs. or older

Date

Parent/Guardian Signature

Date

Witness

Date

Relationship of Witness

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

AUTHORIZATION FOR RELEASE OF INFORMATION: SCHOOL SYSTEM

I (We) authorize Jodi Province Counseling Services, PLLC to release and disclose information from the clinical record of: _____

Name of client/recipient of mental health services _____ Date of birth to, and allow such information to be inspected and copied by: _____

Facility/Provider/Address Nature of information to be disclosed: Recommendations to aid in school performance, diagnosis.

State specific nature of information to be disclosed

For the purposes of School-based therapy and coordination of care with school personnel for wrap around care.

State specific purpose of information to be disclosed

Information to be released and/or exchanged includes any available substance use/abuse or HIV/Infectious disease information as verified by client initials: yes _____ no _____

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Jodi Province Counseling Services, PLLC office. I understand that a revocation is not valid to the extent that Jodi Province Counseling Services, PLLC office has acted in reliance on such authorization. This authorization is valid until _____ (Date)

A copy of this release shall have the same force and effect as the original. By signing below I acknowledge that I have been notified that release/disclosure of information may only occur with a consent unless it is an emergency or for other exceptions as detailed in the General Statutes or in 45 CFR 164.512 of HIPAA.

Client Signature 12 yrs. or older /
Date

Date

Parent/Guardian Signature

Witness / Date

Guardian's Relationship to Client

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for redisclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

Child/Adolescent Name: _____

TRAUMA SCREENING QUESTIONS:

Place a check in the box for each type of trauma /loss experience that has occurred.

- ☐ **Serious Accident:** Like a serious car, bus, train or bicycle accident or a bad fall where you or someone else was or could have been badly hurt or killed? OR have you ever witnessed a bad accident where someone was badly hurt or killed?
- ☐ **Illness/Medical Trauma:** Have you ever been so sick that you or people taking care of you were scared that you might die? Did you have a medical concern that was very scary or painful? Did you ever see someone you really care about get so sick that you were scared they might die?
- ☐ **Community Violence:** Did you ever see a bad fight or shooting in your community? Were you afraid of getting badly hurt or killed? Have you seen someone robbed, stabbed, beaten up, or killed in your community?
- ☐ **Domestic Violence:** Have you ever seen adults you live with get in a bad fight with each other, where someone got punched, kicked or hit with something? Have adults you live with threatened to hurt each other? Have you ever seen an adult you live with forced to do something sexual by another adult you live with?
- ☐ **School Violence/Emergency:** Were you ever at school when something really scary happened, like a shooting, stabbing? Or were you or someone else got badly beaten up or someone attempted or committed suicide?
- ☐ **Physical Assault/Abuse:** Have you ever been badly physically hurt (punched, kicked, stabbed) by someone outside of your family or who was not taking care of you?
- ☐ **Disaster:** Have you ever been in a natural disaster, like a hurricane, tornado, earthquake, flood where you were hurt or could have been hurt or killed? Have you been in a natural disaster where you saw someone badly hurt or killed?
- ☐ **Sexual Abuse:** Did someone who was taking care of you ever force you to do something sexual? Did someone taking care of you ever make you watch something sexual?
- ☐ **Neglect:** Has there ever been a time when someone who should have been taking care of you didn't, like they didn't take you to a doctor when you were really sick, they left you alone for too long, didn't make sure you were going to school or didn't do their best to keep you healthy or safe?
- ☐ **Psychological Maltreatment/Emotional Abuse:** Did anyone in your family ever keep telling you that you are no good, keep yelling at you or keep threatening to or send you away?