Therapy Charlotte LLC

Nicole Saunders, LCSW: *Counseling & Coaching*

Thank you for choosing to work with Nicole Saunders, LCSW. Please read through the following practice policies. Should you have any questions or concerns, please don't hesitate to share.

Your Rights

- To receive quality professional services.
- To be assured privacy and confidentiality.
- To review and discuss your fee for services.
- To refuse service at any time.
- To see your record of service upon written request and to insert a written statement into the record about services received or not received.

Your Responsibilities

- To be on time for scheduled appointments.
- To pay fees for services according to practice policy.
- To actively participate in your own treatment.
- **To give 24 hours' notice if canceling an appointment. Failure to do so will result in a $140 cancellation fee.**

Nicole Saunders has the right and responsibility to determine the client(s) with whom she cannot appropriately and ethically serve. She also has the right to refuse or discontinue services when the client's responsibilities are not being met or the client does not meet her guidelines for service.

PRACTICE POLICIES

CONSENT TO TREATMENT I hereby grant my permission for any counseling, coaching, testing, or diagnostic evaluation that may be needed in treatment. The sessions and records are strictly confidential except where state law requires the reporting of threats of violence, harm to self or others, or child abuse and neglect (from evidence or suspicion), when the courts subpoena information, and when information is needed for billing. If providing couples or family counseling, Nicole Saunders will not keep individual confidential information that could be detrimental to the relationship.

Being aware that there may be potential for emotional strains, stresses, and life changes as a result of counseling or coaching, I agree to enter the process. I understand that Nicole Saunders does not guarantee any particular results or outcomes. I am aware that Nicole Saunders does not provide emergency services.

FINANCIAL POLICIES I accept financial responsibility for charges I incur during the course of treatment. I also understand that if I have insurance coverage and choose not to or cannot use it, I will be assessed the full fee of $200 for an initial session and $150 for all subsequent sessions, except when other arrangements have been made.

- Clients are required to pay their fees at the time of service. **Clients must provide 24 hours' advance notice if canceling an appointment. Failure to do so results in clients being charged a cancellation fee of $140.** Any check returned for insufficient funds must be paid plus a $25 fee prior to being seen or rescheduled.
- Clients using insurance coverage will be responsible for full payment of their fees. While Nicole Saunders will continue to make every effort to collect from a client's insurance company, the client will be held responsible for any **unreimbursed balances if the insurance company does not pay.**
- All accounts that are not paid within 90 days from the date of service will be considered past due. Unless other arrangements have been made, past due accounts will be turned over to a collection agency and Nicole Saunders will provide the collection agency with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account.

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PERSONAL HEALTH INFORMATION POLICY I understand that any of my personal information contained within the designated record set may be used and/or disclosed by Nicole Saunders for purposes of carrying out treatment, obtaining payment (which includes submitting claims to insurance companies), and caring out our health care operations of the organization. I have been offered a copy Nicole Saunders' Notice of Privacy Practices, which I understand provides a more complete description of possible uses and disclosures of my health information. I also understand that the terms of the Notice of Privacy Practices that is in effect at any given time (whether or not it has ever been changed) by requesting a copy.

I understand that I have a right to request that Nicole Saunders restrict how my health information is used or disclosed to carry out treatment, payment or other health care operations, but I also know that Nicole Saunders is not required to agree to any such request. I understand that if Nicole Saunders agrees to my request, the restriction will be binding on Nicole Saunders.

I understand that I have a right to revoke this consent by submitting a written revocation. I also understand that, if I choose to revoke my consent, it can only be revoked to the extent that Nicole Saunders has not acted in reliance upon the consent.

ACKNOWLEDGMENT OF UNDERSTANDING By signing below, I hereby voluntarily and knowingly consent to allow Nicole Saunders to disclose my health information as deemed appropriate to carry out treatment, payment and /or health care operations of the organization.

- ◯ I have received and reviewed my Client Rights and Responsibilities and understand how my information may be used for the purposes of treatment, obtaining payment, and carrying out healthcare operations.
- ◯ I have received and reviewed Nicole Saunders' Privacy Notice explaining how my Protected Health Information (PHI) will be protected and I understand the conditions under which this information will be released.
- ◯ I declare that I am legally competent and that I have the capacity to consent to my treatment and/or to the treatment of family members of whom I am the parent or guardian.
- ◯ If I am using insurance, my signature below serves as my "signature of file" and Nicole Saunders is authorized to release necessary information required to file insurance claims.
- ◯ If my insurance company does not pay, I understand that I am ultimately responsible for the full session fee.
- ◯ I have reviewed Nicole Saunders' financial policy. I am aware of the circumstances for which I will incur additional charges and agree to meet my financial obligation. I agree to give 24 hours' notice before canceling an appointment or I will pay the cancellation fee of $140.

I have read the statements above and have been given the opportunity to ask questions. My signature below indicates that I understand the information I've received and agree to abide by the policies of Therapy Charlotte LLC as described above.

Counselor/Coach Signature	**Date**	**Signature of Client(s)**	**Date**

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INDIVIDUAL COUNSELING INTAKE FORM

Please complete this form and bring it to your first appointment. If you believe that a question does not pertain to you, just leave it blank. The information you provide here is protected by law and held in strict confidence.

Full Name:_____ Date:_____

Birth Date: _____/_____/_____ Current Occupation: _____

Home Address: _____

City/State:_____ Zip: _____

Primary Phone: _____May I leave a message? ☐ Yes ☐ No

E-mail: _____ May I email you?* ☐ Yes ☐ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Insurance Provider: _____ Member ID #: _____

Provider Phone # (on the back of your insurance card): _____

Name of emergency contact: _____ Phone #: _____

Name of Primary Care Physician: _____

Have you ever received any type of mental health services (counseling, hospitalization, psychiatric services, etc.)?

☐ No ☐ Yes, please explain: _____

What mental health medication are you currently taking? _____

What medication(s) in the past for mental health that you're no longer taking?

_____

How did you hear about Therapy Charlotte?

☐ Internet search ☐ Good Therapy Directory

☐ Referred by a friend/acquaintance ☐ Other:_____

☐ Psychology Today Directory

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AREAS OF CONCERN: Please check all items below that help describe your concerns and symptoms.

_____Anxiety or nervousness in general

_____Loneliness

_____Relationship issues

_____Family issues

_____Self-esteem or personal growth

_____Eating issues

_____Body image

_____Sexuality problems

_____Drugs/Alcohol abuse

_____Impulse control issues

_____Managing anger

_____Mood swings

_____Depression or feeling low

_____Cutting, hitting or burning yourself

_____Thoughts of suicide or homicide

_____Sleeping difficulties

_____Grief in response to a loss or death

_____Trouble adjusting to a recent life change

_____Sexual orientation

_____Spiritual identity

_____Feeling detached from the world

_____Victim of abuse or assault

_____Struggling to perform in career or school

_____Career identity or planning issues

_____Perfectionism or procrastination

_____Difficulty concentrating

_____Other:_____

What is the most important thing that you would you like to accomplish in our meeting today?

_____

_____

_____

_____

_____