CAROLINA WELLNESS SOLUTIONS COUNSELING AND CONSULTING, PLLC
PATIENT INTAKE FORM

PATIENT INFORMATION

Name: ____ **Soc. Sec. #** ________________________
Last Name **First** **MI**

Address: ____

City: ____ **State:** ________ **Zip:** _________________

Home Phone: _________________ **Work/Mobile:** ____________________ **Email:** ____________________________

Sex: __________ **Age:** ________ **DOB:** _______ **Single** **Married** **Widowed** **Separated** **Divorced**

Employer/School: ________________________________ **Occupation or Grade:** ____________________________

Whom may we thank for referring you? ___________________________ **Emergency Contact:** ________________

PRIMARY INSURANCE

Person responsible for account ____
Last Name **First Name** **MI**

Relationship to Patient: ____ **DOB:** _______________________

Address (if different from patient): ____

City: ______________________________ **State:** ________ **Zip:** __________ **Phone:** ____________________________

Person Responsible Employed By: ________________________________ **Occupation:** _______________________

Insurance Company: _______________________ **Ins. ID#:** ____________________ **Group#:** ____________________

Do you have secondary insurance? Y/N If yes, please specify ____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ________________________________
Name of Insurance Company

And assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am responsible for all charges accumulated. I hereby authorize Carolina Wellness Solutions to release all information necessary to secure payment of benefits and authorize the use of this signature on all insurance submissions.

____ ________________________________ ____________________
Responsible party signature **Relationship** **Date**

I give permission for treatment of myself/my dependent to Carolina Wellness Solutions

____ ________________________________ ____________________
Responsible party signature **Relationship** **Date**

YOUR CLIENT RIGHTS

You have the right to be treated in a considerate, safe and respectful manner, without discrimination as to race, ethnicity, color, disability, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You may also request that I refer you to another therapist and are free to end therapy at any time.

The North Carolina General Statutes and Administrative Code outlines rules and regulations about Consumer Rights. It is important that your rights are protected. It is important that your rights are not violated.

Consumer Rights include, but are not limited to:

-You have the right to dignity, privacy, and humane care

-You have the right to be free of mental abuse, physical abuse, neglect or exploitation

-You have the right to treatment, including access to medical care and habilitation, regardless of your age or degree of your mental health, developmental disabilities, or substance abuse. The treatment you receive will be age appropriate.

-The right to receive information about the organization/practice, its services, its practitioners/providers, and member rights presented in a manner appropriate to consumers ability to understand.

-The right to participate with your provider in making decisions regarding health care, including the right to refuse treatment.

-You have the right to refuse treatment at any time. However, it is strongly encouraged that you discuss this with your provider.

-The right to a candid discussion with your provider of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. Clients may need to decide among relevant treatment options, the risks, benefits, and consequences including their right to refuse treatment and to express their preferences about future treatment decisions regardless of benefit coverage limitations.

-The right to voice complaints or appeals about the organization/practice or the care it provides.

-The right to be free from any form of restraint or seclusion used a means of coercion, discipline, convenience, or retaliation

-The right to request and receive a copy of his or her medical record subject to therapeutic privilege, as set forth in NC G.S. 122C-53(d) and to request that the medical record be amended or corrected in accordance to 45 C.F.R Part 164 and the provisions of NC G.S. 122C-53(d). If the doctor or therapist determines that this would detrimental to the physical or mental well-being of the person, they can request that the information be sent to a physician or professional of his/her choice.

-The right to participate in the development of a written person-centered treatment plan that builds on individual needs, strengths, and preferences. A treatment plan must be implemented within 30 days of admission.

-The right to take part in the development and periodic review of a treatment plan and to consent to treatment goals in it.

-The right to freedom of speech and freedom of religious expression.

-The right to treatment in the most normal, age-appropriate, and least restrictive environment possible.

-The right to make recommendations regarding the organization's member rights and responsibilities policy.

-Your care is confidential. Even the fact that you are receiving services is confidential. Information about you can only be shared when:

1. You have given written consent
2. You have been ordered by a court of law
3. You have become a danger to yourself or others and it is necessary for someone to submit involuntary commitment papers or find hospital placement for you
4. You are likely to commit a serious crime. Your provider will share the information with the appropriate law enforcement agency.

What to do if I want to file a complaint or grievance?

We encourage you to discuss your concerns directly with your provider. However, we are aware that there are times when issues cannot be resolved. Sometimes you may feel that you are not able to discuss your concerns with your provider. If you would like to talk about your complaint or grievance with someone other than your provider, you can call:

-North Carolina Board of Licensed Clinical Mental Health Clinicians at 844-622-3572 or 336-217-6007

-Disability Rights of North Carolina number are 1-877-235-4210 and 1-919-856-2195

Patient Signature (or guardian)____Date__________________

Name of Patient____Date__________________

Therapist Signature____Date__________________

CAROLINA WELLNESS SOLUTIONS COUNSELING AND CONSULTING, PLLC
INFORMED CONSENT FORM

Client Name:_______________________________________ **Date of Birth:**_____________

Client MIN:____

Welcome to Carolina Wellness Solutions Counseling and Consulting, PLLC. This document contains important information about our professional services and business policies. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign thIs document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Carolina Wellness Solutions Counseling and Consulting, PLLC provides services to indivIduals and/or families who may experience emotional, developmental, social, marital/couples, and substance abuse problems. Our therapists are trained to provide appropriate treatment as needed to help the individual and/or famiIy.

While I expect benefits from treatment, I fully understand and accept that because of factors beyond our control, such benefIts and desired outcomes cannot be guaranteed.

I understand that the therapist(s) are not providing emergency services and I have been informed of who/where to call in an emergency.

I understand that regular attendance will produce the maximum possible benefits but that I or my child are free to discontinue treatment at anytime in accordance with the policies of the office.

I have been informed of the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threat of harm to myself or another person.

I am not aware *of any* reason why my child or I should not proceed with therapy and my child or I agree to prticipate fully and voluntarily.

I have had the opportunity to discuss all aspects of treatment fuIly, have had my questions answered, and understand the treatment planned. Therefore, I agree to comply with treatment and authorize Carolina Wellness SolutIons Counseling and Consulting, PLLC to provide the treatment to my child or myself.

I, ____________________________________ authorize Carolina Wellness Solutions Counseling and Consulting, PLLC to contact individual and/or physical/hospital in the event that I become incapacitated due to an emergency illness or accident while in treatment.

Name of Physician/Hospital: ______________________________________ Telephone:_______________

Name of Emergency Contact: ______________________________________ Relationship:_____________

Telephone:___________________________________ Work/Cell:__________________________________

INFORMED CONSENT CONTINUED

OFFICE BILLING AND INSURANCE POLICY

- **I authorize use of this form on all my insurance submissions.**
- **I authorize the release of information to my insurance company.**
- **I understand that I am responsible for the full amount of my bill for services provided.**
- **I authorize direct payment to my service provider.**

Patient Signature (or guardian):__________________________________**Date:**____________________

Cancellation/No Show Policy

There is a **24-HOUR CANCELLATION POLICY**, which requires that you cancel your appointment AT LEAST 24 HOURS in advance or you may be charged the full session fee of $175. If special services are required for the appointment, there is a 48-hour cancellation policy. Please be mindful that your clinician reserves appointment time for you. If you are unable to make your appointment, please notify me, as I can use the time for another person in need. I will work with your schedule to provide you with another appointment. Three (3) no show/cancelled appointments with less than 24 hours' notice may result in discharge of services from Carolina Wellness Solutions Counseling and Consulting PLLC. Your service provider will work with you to find another provider that meets your needs. In addition, your therapist reserves the right to charge the cost of a full session charge for no show or improperly cancelled appointments. Please be aware that your insurance company does not cover this fee.

Contacting your Clinician:

I/We may often not be immediately available by telephone. I do not answer my phone when I/We are with clients or otherwise unavailable. At these times, you may leave me a message on our confidential voice mail and your call will be returned as soon as possible, but it may take up to 24 hours for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I/We are unable to reach you, please give us another call. You may also email your counselor at krsmetak@yahoo.com or jodiesmetak@yahoo.com. I/We will make every attempt to inform in advance of planned absences and provide you with the name and phone number of the mental health professional(s) covering our practice. IF YOU HAVE A MEDICAL EMERGENCY, PLEASE CALL 911 OR GO TO NEAREAST EMERGENCY ROOM. IF YOU HAVE A BEHAVIORAL HEALTH EMERGENCY, PLEASE CONTACT THE AFTER HOURS LINE AT 704-648-3420. (YOU MAY NEED TO LEAVE A MESSAGE AND YOUR CALL WILL BE RETURNED WITHIN THE HOUR). I OFFER APPOINTMENTS WITHIN 48 HOURS FOR URGENT CARE NEEDS.

OTHER HELPFUL CRISIS LINES:
-National Suicide Prevention Lifeline: 988

Patient Signature (or guardian):__________________________________**Date:**____________________

INFORMED CONSENT CONTINUED

CONFIDENTIALITY

All sessions are confidential and protected by the HIPAA law and my ethical standards through my licensing board. There are some limits to confidentiality, such as reporting child or elder abuse, when you are in danger of hurting yourself or someone else or when the courts order your records. Otherwise, your information is confidential unless you ask me to share it with a third party. If this happens, the request will take place in writing. Special note on confidentiality with children and adolescents: Psychotherapy with people of any age relies on the client's confidence that what is shared with the therapist is private and confidential. While parents and guardians have the right to know general information about how therapy with their child is progressing, in signing this form you have waived the right to know the private details of the child's therapy or to have access to the confidential therapy records of the child. A general summary can be provided at any time upon request. I will check in with parents at the beginning of each session for an update or to address any concern. If there is an issue or concerns of great importance, I will encourage your child to share this information.

LENGTH OF SESSION AND FEES

A therapy session can last anywhere from 45-75 minutes. We will schedule these sessions based on our mutual agreement. If you are unable to keep an appointment, please give at least 24-hour notice as that time can be used for another person in need and to prevent possibly being charged the full session fee. Appointments that are consistently missed or cancelled can result in termination of the therapy. An appropriate referral will be given to you if this occurs. Carolina Wellness Solutions Counseling and Consulting Services, PLLC currently accepts some Blue Cross Blue Shield Insurance Plans, Cigna, Aetna, Healthy Blue, and self-pay clients. If you have other insurances, you will be responsible for payment up front and receiving a reimbursement from your insurance company. A sliding scale can be used with self-pay and other insurance clients.

COMPLAINT PROCEDURES

If you are dissatisfied with any aspect of this practice, please inform your clinician immediately. We will work with you to resolve the matter. If you feel that this matter can't be resolved with your clinician, you can contact:
-North Carolina Board of Licensed Mental Health Counselors at 844-622-3572
-Disability Rights of North Carolina numbers are 1-877-235-4210 and 1-919-856-2196

Thank you again for choosing Carolina Wellness Solutions Counseling and Consulting Services, PLLC as your provider. If you have any questions or comments, please feel free to inform me.

______________________________	______________
Client/Guardian Signature	**Date**
______________________________	______________
Therapist Signature	**Date**

CLIENT NAME:____________________________________ **DOB:**_________________________

MIN/RECORD #:__________________________________ **DATE:**_________________________

AUTHORIZATION FOR RELEASE, DISCLOSURE, AND EXCHANGE OF INFORMATION

I/We authorize Carolina Wellness Solutions Counseling and Consulting, PLLC, 100 Glenway Street, Suite F, Belmont, NC 28012, to release, disclose, and exchange 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 of Facility/Provider

Nature of information to be released, disclosed, and exchanged (state specific nature of information):

____

____

Re-Disclosure: Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law (45 CFR Part 164) may not apply to the recipient of the information and, therefore, may not prohibit the recipient of the information from re-disclosing it. Other laws, however, may prohibit re-disclosure. When information is released from this practice protected by state law (NCGS 122C), substance abuse treatment information protected by federal law (42 CFR, part 2) or state law (G.S>130A-143), HIV/AIDS information the recipient of the information is informed that re-disclosure is prohibited except as permitted or required by these laws. I understand that I may revoke this consent in writing at any time, except where action has already been initiated on the authorization. Per 10A NCAC 26B.0202, the individual must specifically authorize the release/disclosure of information which contains Substance Abuse information and/or HIV/AIDS information.

I authorize release/disclosure of information which contains Substance Abuse Information: Yes___ No___

I authorize release/disclosure of information which contains HIV/AIDS information: Yes___ No___

This authorization is valid until _______________ (not to exceed one year from date of signature)
Date

I understand that signing this authorization is voluntary. Provision of services is not contingent upon consent and of the need for release.

______________________________________	______________________________________
Client Signature 12 years or older Date	**Parent/Guardian Signature Date**
______________________________________	______________________________________
Clinician Signature Date	**other witness if needed Date**

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

______________________________	______________________________
Client Name	**Guardian Name**
______________________________	______________________________
Client or Guardian’s Signature	**Relationship to Client**
______________________________	
Date	

TREATMENT PLAN

CLIENT NAME:______________________________________ **DOB:**_____________________

RECIPIENT ID/MIN #:_________________________________ **RECORD#:**_________________

Diagnosis:

Presenting Problem 1:

Goal 1:

Interventions:

Start Date: **End Date:** **Review Dates:**

Presenting Problem 2:

Goal 2:

Interventions:

Start Date: **End Date:** **Review Dates:**

Presenting Problem 3:

Goal 3:

Interventions:

Start Date: **End Date:** **Review Dates:**

Client Signature:____ **Date:**_______________

Parent/Guardian Signature:____ **Date:**_______________

Clinician Signature:____ **Date:**_______________

CAROLINA WELLNESS SOLUTIONS COUNSELING AND CONSULTING PLLC

EMAIL CONSENT FORM

Carolina Wellness Solutions now has an email newsletter! Once we have your consent and email address, you will receive an email version of our newsletter along with communications about upcoming events, groups, and other creative opportunities.

Carolina Wellness Solutions will not share your email address with any other entity and will only use it to send the communication mentioned above. Your email address will not be visible to others on the email list. If you would like to unsubscribe in the future, let us know or click "unsubscribe" on any of the emails.

CONSENT

I, ____________________________________ give consent to Carolina Wellness Solutions Counseling and Consulting Services, PLLC to send the communications mentioned above to the following email address:____

Signature:____ **Date:**______________

____________**No, I do not want to receive emails**