CAPSTONE WELLNESS CENTER

POST OFFICE BOX 192
SPARTA, NORTH CAROLINA 28675
PHONE: 336-467-0489
888-507-1025
FAX: 888-507-3159

115 ATWOOD STREET, SUITE 413
SPARTA, NORTH CAROLINA 28675

189 SAMARITAN'S RIDGE ROAD
ELKIN, NORTH CAROLINA 28621

New Client Intake Packet

Patricia Poovey Andrews
Licensed Professional Counselor
North Carolina #900

My name is Patricia (Pam) Andrews and I am a Licensed Professional Counselor, National Certified Counselor and Licensed Professional School Counselor with more than 30 years experience working with the mental health, developmental disability and substance abuse populations from all age groups. I earned a Master's Degree in Agency Counseling and advanced licensure in school counseling from Appalachian State University. I am devoted to providing my clients with clinically appropriate treatment in the most respectful manner possible. All services provided respect your rights to confidentiality and privacy. Our work together will be a collaborative or team effort in which we both work to achieve clearly formulated treatment/assessment goals. Please, feel free to ask any questions you may have regarding treatments, payments, or me.

If you have any questions or would like additional information, please feel free to ask.

Mandatory Disclosure Statement
Client Rights and Important Information

You are entitled to receive information from me about my methods of counseling, the technique I use, the duration of your assessment and my fee structure. I will provide you with this information in our first meeting.

As a client, you have the right to choose a counselor who best suits your needs and purposes. Please, be advised that you may ask questions about treatment at any time, and you may also choose to terminate/end counseling at any time.

In Case of Emergency

If you have an urgent situation that you believe needs immediate support and I am not available in my office or by phone, please contact one of the following:

1) Your Primary Care Physician
2) Go to the nearest hospital emergency room

For LME/MCO or Medicaid Clients: You may call the Partners Behavioral Healthcare 24-hour / Crisis Number: 1-888-235-4673.

Termination of Treatment

If you decide to terminate therapy, you understand that it can be helpful to discuss termination with your therapist. Patricia Andrews reserves the right to discontinue therapy due to continual cancellations, lack of payment, etc.

Initial _____

Complaint Procedures

If you are dissatisfied with any aspect of the counseling/assessment process, please inform me so we can determine if our work together can be more efficient and effective or if referral is appropriate.
If you think I have treated you unfairly or unethically, and we cannot resolve the problem, contact: The North Carolina Licensed Professional Counselor Board or Disability Rights of North Carolina Complaint Hotline: 1-800-624-3004 (within N. C.) or 919-855-4500.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential with some exceptions.

Initial _____

Privileged Communication

Sections from Chapter 8 of the North Carolina General Statutes:

Sec. 8-53.3. Communications between counselor and client or patient.

No person duly authorized as a licensed psychologist or licensed psychological associate, nor any of his or her employees or associates, shall be required to disclose any information which he or she may have acquired in the practice of psychology and which information was necessary to enable him or her to practice psychology. Any resident or presiding judge in the district in which the action is pending may, subject to G.S. 8-53.6, compel disclosure, either at the trial or prior thereto, if in his or her opinion disclosure is necessary to proper administration of justice. If the case is in district court the judge shall be a district court judge, and if the case is in superior court the judge shall be a superior court judge.

Notwithstanding the provisions of this section, the psychologist-client or patient privilege shall not be grounds for failure to report suspected child abuse or neglect to the appropriate county department of social services, or for failure to report a disabled adult suspected to be in need of protective services to the appropriate county department of social services. Notwithstanding the provisions of this section, the psychologist-client or patient privilege shall not be grounds for excluding evidence regarding the abuse or neglect of a child, or an illness of or injuries to a child, or the cause thereof, or for excluding evidence regarding the abuse, neglect, or exploitation of a disabled adult, or an illness of or injuries to a disabled adult, or the cause thereof, in any judicial proceeding related to a report pursuant to the Child Abuse Reporting Law, Article 3 of Chapter 7B, or to the Protection of the Abused, Neglected, or Exploited Disabled Adult Act, Article 6 of Chapter 108A of the General Statutes.

Initial _____

Release of Information

You will receive a copy of your (or your child's) treatment plan/assessment and may request a copy at any time. If you would like for me to release your records to another provider/agency/school, you may request a Release of Records Form. All requests disclosure of health information must be in writing and signed by the parent/legal guardian/personal representative. Legible facsimiles are acceptable. A release form will be provided upon request. The signed form can be mailed or faxed.

Mail to: Post Office Box 192
Sparta, North Carolina 28675

Fax to: 1-888-507-3159

Initial _____

Clients Rights General Statutes 122C-51 Declaration of Policy on Client's Rights.

It is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, human care, and freedom from mental and physical abuse, neglect, and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment. It is further the policy of this State that each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities.

Assessment and Treatment or Service Plan. The plan shall include: written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

Disability Rights North Carolina is a private non-profit organization. Designated by the Governor in 2007 to ensure the rights of all state citizens with disabilities through individual advocacy and system change, DRNC is part of a national system of federally mandated independent disability agencies. DRNC is completely independent of government and the disability service system in order to be free of any conflicts of interests which would undermine our capacity to advocate vigorously on behalf of the human and legal rights of people with disabilities. If you feel your rights are being violated or that you require assistance, you may contact Disability Rights of North Carolina.

Address: 2626 Glenwood Avenue Suite 550, Raleigh, North Carolina 27608
Telephone: Voice (919) 856-2195, Toll Free Voice (877) 235-4210, TTY 888-268-5535
Fax: (877) 235-4210
Email: info@disabilityrightsnc.org

New Client Information Package

Initial _____

TREATMENT AGREEMENT

It is understood that the client, not the client's insurance company or the client's employer, is responsible for the full payment of services rendered. The client is responsible for co-pay/coinsurance, unmet deductibles, and any unpaid insurance balance **at the time of each visit.** If you would like an insurance billing form sent to your insurance company, then please sign below.

If a schedule appointment is missed, a charge of $50.00 will be made unless the appointment is cancelled 48 hours in advance. If two or more appointments are missed without 48 hours notice, the client may be dismissed from the practice for a period of 3 - 6 months.

FINANCIAL RESPONSIBILITY: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services rendered to the patient, he/she hereby individually is obligated to pay Pam Andrews, M. A. the full charges as incurred over the course of treatment, including those fees not paid by the insurance carrier and/or other sources of financial support or benefit. In the event that it might become necessary to refer the account to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. Please discuss these matters with Pam Andrews if you have any further questions.

I authorize the release of insurance company of the required medical information necessary to process this claim. I authorize the payment of medical/psychotherapy benefits to the named provider for services rendered.

Your signature below indicates that you have read and received a copy of this document and had the opportunity to ask any questions.

_____ _____

Printed Name *Relationship to Client*

_____ _____

Signature *Date*

TO ENABLE MY THERAPIST WITH ACCURATE AND CONFIDENTIAL SERVICES, PLEASE COMPLETE THE FOLLOWING:

Please be aware that fax transmissions arrive at Capstone Wellness Center Office and are distributed to the individual provider. Confidentiality is maintained with these records, as with all records in our office.

Messages regarding appointments may be left on my voicemail: Yes _____ No _____

Email may be used to communicate with me: Yes _____ No _____

Email Address: _____

Text message may be used to communicate with me: Yes _____ No _____

Cell Phone Number: _____

The following individuals may schedule and/or confirm an appointment:.

_____ Relationship _____

_____ Relationship _____

INSURANCE INFORMATION:

Insurance Company: _____ Name of Insured: _____

Insured's Social Security #:_____ Insured's Date of Birth: _____

Insured's Policy #: _____ Insured's Group # _____

Insured's Employer: _____ Amount of Co-Pays: _____

To be Completed by Therapist:

Primary Diagnosis _____

Secondary Diagnosis _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ **Date of Birth** _____

Client Medical Record # _____ **Client SS #** (Optional) _____

I _____ hereby authorize _____
(Client or Personal Representative) *(Name of Provider/Plan)*

to disclose specific health information from the records of the above named client to: (Recipient Name/Address/Phone/Fax)

_____

_____

_____

for the specific purpose(s): _____

_____

Specific information to be disclosed:

_____

_____

_____

I understand that this authorization will expire on the following date, event or condition:

_____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorizations is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that any information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state and federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness - If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE: This Authorization was revoked on _____ (Date) _____ (Signature of Staff)

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REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

Signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the rescinded
(Date)

date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by
_____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any action taken
(Date)

on this authorization prior to the rescinded date is legal binding.

_____	_____	_____	_____
(Signature of Staff)	*(Date)*	*(Signature of Witness)*	*(Date)*

New Client Information

Please complete all information on this form. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email _____

Emergency Contact _____Relationship _____ Phone _____

Date of Birth _____ Social Security # _____

Primary Care Physician _____ Phone _____

Do you give permission for ongoing regular updates to be provided to your primary care physician? ( ) Yes ( ) No

Current Therapist/Counselor _____ Therapist's Phone _____

If Child:

School _____ Phone _____ Grade _____

IEP/504/Medically Fragile _____ Special Education Classes _____

What are the problem(s) for which you are seeking help?

1) _____

2) _____

3) _____

What are your treatment goals:

_____

_____

Educational History:

Highest Grade Completed _____

Where _____

Did you attend college ( ) Yes ( ) No Where _____

Major or Field of Study _____

Highest Educational Level or Degree Attained _____

Occupational History:

Are you currently ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position _____ Where do you work _____

What is/was your occupation _____

Have you ever served in the military _____ If so, what branch and when _____

Honorable Discharge ( ) Yes ( ) No Other type discharge _____

Legal History:

Have you ever been arrested ( ) Yes ( ) No

If so, please provide details _____

Do you have pending legal problems ( ) Yes ( ) No

If so, please provide details _____

Relationship History and Current Family:

Are you currently ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed…..How long _____

If not married, are you currently in a relationship ( ) Yes ( ) No If yes, how long _____

Describe your relationship with your spouse or significant other _____

_____

Have you had any prior marriages ( ) Yes ( ) No If so, how many _____ How Long _____

Do you have children ( ) Yes ( ) No

If yes, list ages and gender _____

_____

_____

Describe your relationship with your children. List everyone who currently lives with you._____

_____

_____

Current Symptoms Checklist: *(check once for any symptoms present, twice for major symptoms)*

Symptoms	***Check Once for Present Twice for Major***	***Describe***
Depressed Mood		
Unable to Enjoy Activities		
Sleep Pattern Disturbance		
Loss of Interest		
Concentration /Forgetfulness		
Change in Appetite		
Excessive Guilt		
Fatigue		
Decreased Libido		
Increased Libido		
Racing Thoughts		
Impulsivity		
Increased Risky Behavior		
Decreased Need for Sleep		
Excessive Energy		
Increased Irritability		
Crying Spells		
Excessive Worry		
Anxiety Attacks		

Avoidance		
Hallucinations		
Suspiciousness		
Other		

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

_____

Medical History

Allergies _____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	***Total Daily Dosage***	***Estimated Start Date***

Current Over-the-Counter Medications or Supplements

_____

_____

Current Medical Problems

_____

_____

Past Medical Problems, Hospitalizations or Surgeries (Non-Psychiatric)

_____

_____

Family Background and Childhood History

Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____ For how long? _____

Describe your father and your relationship with him:

_____

_____

Describe your mother and your relationship with her:

_____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? ( ) Yes ( ) No Who and when? _____

_____

Trauma History

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No

Please describe when, where and by whom: _____

_____

_____

_____

Personal and Family Medical History

	You	***Family Member***	***Which Family Member***
Thyroid Disease			
Anemia			
Liver Disease or Problems			
Chronic Fatigue			
Diabetes			
Asthma/Respiratory Problems			
Stomach or Intestinal Problems			
Cancer (Type)			
Fibromyalgia			
Heart Disease			
Epilepsy or Seizures			
Chronic Pain			
High Cholesterol			
High Blood Pressure			

Head Trauma			
Other (list)			

Are there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

_____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

	Yes	***No***	***If Yes, Who Had Problem***
Bipolar Disorder			
Depression			
Anxiety			
Anger			
Suicide			
Schizophrenia			
Post-Traumatic Stress			
Alcohol Abuse			
Other Substance Abuse			
Violence			

Your History

Past Psychiatric History

Outpatient Treatment ( ) Yes ( ) No If yes, please describe when, by whom, and nature of treatment.

Reason	***Dates***	***With Whom***	***Nature of Treatment***

Psychiatric Hospitalization ( ) Yes ( ) No If yes, please describe for what reason, when and where.

Reason	*Dates*	*Where*	*Nature of Treatment*

Substance Use

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____ The most number? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

_____

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones?

_____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

_____

How many caffeinated beverages do you drink in a day? Coffee _____ Sodas _____ Tea _____

Energy Drinks _____

Tobacco History

Do you currently smoke cigarettes? ( ) Yes ( ) No

How many packs per day on average? _____ How many years? _____

Anything Else You Would Like Me to Know

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature ***Date***

_____ _____

Guardian Signature (if under age 18) ***Date***

_____ _____

Emergency Contact (and relationship) ***Telephone Number***

****

For Office Use Only:

Reviewed by _____ Date _____

Reviewed by _____ Date _____