LORALIE GRIGAS, MSW, LCSW, LCAS, SAE
NEW CLIENT INTAKE FORM

Client Name: *(Last)* _____ *(First)*_____ *(MI)* _____

Address: _____
(Street)

_____ _____ _____ _____
(City) *(State)* *(Zip)* *(County)*

Phone: (Home) _____ (Work) _____ (Cell/Other) _____

May we leave a message at home/cell? ☐ Yes ☐ No **May we leave a message at work?** ☐ Yes ☐ No
Would you prefer appointment reminders to be text message or voicemail? ☐ Yes ☐ No _____

Email address: _____ **May we contact you via email?** ☐ Yes ☐ No

Who Referred you? _____

SS #: _____ - _____ - _____ **Birth Date**: _____ **Age**: _____ **Gender**: ____Male ____ Female

Emergency Contact: _____ _____ _____ _____
(Last) *(First)* *(Phone)* *(Relationship)*

Address: *(Street)*_____ *(City)*_____ *(State)*_____ *(Zip)* _____

Previous Psychiatric Services/Therapy? ____ No ____ Yes **Dates:**_____

Providers:_____

Primary Care Doctor: _____

Address: _____ Phone: _____

Current Medications:

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Household Income (for determining sliding fee): $ _____

Marital Status: ___ Single ___ Married ___ Unmarried Couple ___ Divorced ___ Separated ___ Widowed ___ Other

Legal Status: ___ N/A ___ Court Ordered ___ Court Referred ___ Other _____

Referral Source: ___ Internet ___ Newspaper ___ DSS ___ Court ___ Friend/Family ___ Other_____

Symptoms/Issues: ☐ Separation/Divorce ☐Abuse ☐ School/Work Issues ☐ Legal Charges/Probation ☐ Family/Domestic
☐ Abuse ☐ Anxiety ☐ Attention ☐ DWI ☐ Grief/Loss ☐ Domestic Violence ☐ Drug/Alcohol Use ☐ Marital/Couple
☐ Anger ☐ Depression ☐ PTSD ☐ Assessment/Consultation ☐ Sexual ☐ Impulse Control ☐ Other:

Please Describe Reason(s) for Seeking Services: _____

_____

_____

LORALIE GRIGAS, MSW, LCSW, LCAS, SAE
OFFICE POLICY/CONSENT FOR TREATMENT

Please read and sign below. Signature required for treatment.

Copay & Deductibles: Copays, coinsurance or deductibles associated with your insurance are due at the time you are seen for treatment. Please note that some health insurance policies have a higher copay, coinsurance or deductibles associated with treatment for mental health and/or substance abuse issues which may be different than the copay, coinsurance or deductible you pay for medical appointments. All fees are your responsibility and are payable at the time of service. Insurance will be verified prior to your first appointment to find out what fees will be at your first appointment.

Missed Appointment Charge: A $25.00 fee will be billed to the client for failure to show up for a scheduled appointment, except for unavoidable delays or emergencies. This fee is NOT billable to insurance and will be the sole responsibility of the client and/or the responsible party for the client.

Discharge From Services: You can be discharged from treatment after two "no shows" for failure to show up for a scheduled appointment without giving 24 hour advance notice prior to missing the appointment.

Late Cancellations Fee: A $25.00 fee will be billed to the client for failure to give at least 24 hours advance notice of the need to miss or reschedule an appointment. This fee is NOT billable to insurance and will be the sole responsibility of the client and/or the responsible party for the client.

Returned Check Fee: A $25 fee will be charge for all returned checks. After one returned check, all payments will need to be made in cash or by credit card.

Court Mandated Clients: If you are mandated by the courts or other legal entity, some services may be court mandated. Some services may include telephone consultations with the client and/or family, preparation of reports, court testimony and other non-direct client services. These services are not billable to insurance and will be billed directly to the client or responsible party.

Preparation Fee: A fee of $25 per 15 minutes will be charged for completion of paperwork or letters written on behalf of the client for any purpose. This fee is not billable to insurance and will be billed directly to the client or responsible party. Separate court fees will be charged if Carolina Beach Counseling is served with a subpoena for an appearance in person or a deposition subpoena for appearance to court. Requests for those fees rates can be made at any time.

Consent for Treatment:

1. I have read, understand and accept in full all of the above statements, terms, and conditions for treatment and payment for services rendered by Carolina Beach Counseling.
2. I assign and authorize direct payments of all benefits due for client services to Carolina Beach Counseling. I further agree that if my third party carrier does not pay any part of all these billings, it will be my responsibility to pay the amount due. I agree to be charged late fees of 1.5% each month if my balance is more than 30 days delinquent.
3. I authorize the release of any and all information required for insurance and payment purposes. I understand that a photocopy of this authorization is as authentic as the original signed authorization.
4. I acknowledge that I consent to counseling with Carolina Beach Counseling. I understand I can terminate counseling at any time by notifying my therapist. I will be given the opportunity to participate in the planning of my counseling and I can choose not to accept services here.
5. I declare that I am legally competent and I have the capacity to consent to my counseling and/or the services of family members of whom I am the parent/guardian.

_____	_____	_____
Client Signature	Client Printed Name	Date
_____	_____	_____
Guardian/Insured Signature	Guardian/Insured Printed Name	Date

Loralie Grigas, MSW, LCSW, LCAS, SAE
Client Rights / Grievances Document

Client Rights:

I understand that these are my basic rights. These rights include:

1. The right to impartial access to treatment services regardless of race, religion, ethnic background, physical handicap or source of financial support.
2. The right to have personal dignity recognized and respected in all aspects of interaction and contact with facility staff.
3. The right to individualized treatment, including participation in the development of a treatment plan and implementation of the plan in cooperation with professional staff.
4. The right to confidentially of communication with treatment staff and of material included in the treatment record; federal confidentially rules (42 CFR part 2) prohibits the release of any information about a client's participation in this program to anyone outside of this agency without a client's written authorization for the disclosures of my protected health information.
5. The right to privacy of health information, under H.I.P.A.A., (Health Insurance Portability and Accountability Act). Rules accept where federal or state rules are more restrictive H.I.P.A.A**. Notice of Privacy Practice** is given to all clients extensively explaining the rules and exceptions to confidentiality in special cases of imminent emergency, abuse or court order.
6. The right to express opinions and discuss the plan and course of treatment with persons responsible and to receive a stated grievance in accordance with established policy.
7. The right to be informed in any rules or exceptions, which apply to the client's conduct and participation in treatment.
8. The right to a satisfactory explanation of treatment services and this statement of rights before giving consent to treatment.
9. The right to notify the staff of discontinuance of treatment at any time without being financially responsible for any planned treatment services that was not provided.
10. The right to be informed of alternative treatment resources other than those provided by Carolina Beach Counseling, LLC.

I understand I am also entitled to the following basic human rights which are provided to every client:

1. Right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect and exploitation.
2. Right to treatment and care based on the normalization principle.
3. Right to receive age-appropriate treatment, access to medical care and habilitation, and the right to an individualized written program plan at the time of admission to maximize his/her development.
4. Right to be informed in advance of the potential risks and alleged benefits, and alternatives to the program choices
5. Right to confidentiality.
6. Right to be free from unnecessary or excessive medication. Medication shall not be used for punishment, discipline or staff convenience.
7. Right to consent to or to refuse any treatment offered, including behavior management policies, except in certain emergency situations.
8. Right to request notification after occurrence of any or specified interventions.
9. Right to be informed of emergency procedures.
10. Right to exercise all civil rights. Certain civil rights may be limited if a client has been adjudicated incompetent.
11. Right to certain safeguards and carefully controlled circumstances when interventions are used.

12. Right to be free of corporal punishment, and to be free of harm, abuse and exploitation.
13. Right to be free of restrictive interventions including, but not limited to physical restraint, isolation or seclusion except when there is imminent danger of abuse or injury to oneself or others, when substantial property damage is occurring, or when it's necessary as a part of treatment/habilitation.
14. Right to be free from threat or fear of unwarranted suspension or expulsion.
15. Right to be free from unwarranted invasion of privacy.
16. Right to be free from unwarranted search and/or seizure.
17. Right of the person legally responsible for a minor or an incompetent adult to request notification of the use of an intervention procedure.
18. Right to request notification of the restriction of rights.

Grievance Policy:

I understand that if I have a complaint/grievance, I should: Submit Concerns/Grievances in writing to Carolina Beach Counseling, LLC, Clinical Director at 1328 N. Lake Park Blvd., Suite 109, Carolina beach, NC 28428; phone 910-458-4544; fax 910-458-4824. If unresolved, you may call the North Carolina Division of Mental Health / Developmental Disabilities / Substance Abuse Services, or Disability Rights NC. Please see the information below.

I understand that I have a right to contact the agencies below at any time to discuss my complaint/grievance:

North Carolina Division of Mental Health / Developmental Disabilities / Substance Abuse Services
www.ncdhhs.gov/mhddsas
Advocacy and Customer Service Section: 919-715-3197
DHHS CARE-LINE: 1-800-662-7030 (Voice/Spanish)

Disability Rights NC
www.disabilityrightsnc.org
2626 Glenwood Avenue, Suite 550, Raleigh, NC, 27608
(877) 235-4210 or (919) 856-2195
Email: info@disabilityrightsnc.org

I certify that I have read and understand this Client Rights/Grievance Policy.

Client's Signature: _____ Date: _____

Print Name: _____

Counselor's Signature: _____ Date: _____

Print Name & Credentials:_____

CONSENT FOR THE USE OF PROTECTED HEALTH INFORMATION

Under the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA), LORALIE GRIGAS, MSW, LCSW, LCAS, SAE may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, and healthcare operations. Under HIPAA and North Carolina General Statute 122C-52 through 122C-56, we may disclose Protected Health Information without your expressed consent under certain conditions. For certain statistical report and research purposes, we may also provide information about a group of clients which does not include any information which identifies you individually.

LORALIE GRIGAS, MSW, LCSW, LCAS, SAE policies regarding privacy and confidentiality are summarized in a Notice of Privacy Practices which you may wish to review before giving this consent.

By signing this document, I consent for LORALIE GRIGAS, MSW, LCSW, LCAS, SAE to use of my Protected Healthcare Information as described above and in the Notice of Privacy Practices.

This consent is truly voluntary. I understand that I may provide written notice to LORALIE GRIGAS, MSW, LCSW, LCAS, SAE and revoke this consent at any time except to the extent that action has been taken based upon it. I may request restrictions in the use or disclosure of my PHI. I acknowledge receipt of LORALIE GRIGAS, MSW, LCSW, LCAS, SAE Notice of Privacy practices. I also understand that LORALIE GRIGAS, MSW, LCSW, LCAS, SAE reserves the right to change or amend its privacy practices.

_____ _____

Client signature Date

_____ _____

Personal Representative signature
(Parent, Guardian, etc.) Date

_____ _____

Witnessed by Date

Loralie Grigas, MSW, LCSW, LCAS, SAE

INFORMED CONSENT

BENEFITS/RISKS

It is important that you know what to expect from counseling. Therefore I ask you to read and sign a copy of this informed consent as you begin your therapy.

Once you have established a relationship with a therapist, the particulars of your situation will be discussed with you. Your therapist will present an understanding of the issue on which you want to work, the approach to the issue and the direction that your therapy might take. You will have ample time to consider what is propose of therapy before going forward. If you choose not to continue in therapy please consider the potential consequences/risks associated with this choice.

Counseling can be beneficial to most people who become involved in the process, however this cannot be guaranteed. Your commitment to your own growth will largely determine the benefits you will gain.

LIMITS OF CONFIDENTIALITY

Information communicated between therapist and client will be held in confidence. No information will be released unless you make such a request in writing by signing an authorization to disclose healthcare information.

In order to keep you and/or others safe, there is **no** confidentiality, should you disclose incidents of child or elder abuse, or threats of harm to yourself or someone else. North Carolina law requires reporting of such events.

In most legal proceedings, you hold the counselor/client privilege, which would protect information about your treatment. However, in certain legal situations the counselor/client privilege may not be protected. Your therapist will explain this in detail, if it applies. If you have questions please ask your therapist.

CANCELLATION POLICY

Notify us at least 24 hours before your appointment and you will not be charged. You may either request to reschedule or cancel your session. If your notification is less than 24 hours of your scheduled session, you may be required to pay for the missed session.

I have read and understand 1) benefits/risks of counseling, 2) the limits of confidentiality and, 3) cancellation policies.

Print Name: _____

Signature _____ Date: _____/_____/_____

Notice of Privacy Practices

Under the Healthcare Insurance Portability and Accountability Act of 1996, you have certain legal rights to privacy. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and ask questions about any part that you do not understand.

Protected Health Information and its use for Treatment, Payment, and Healthcare Operations

Protected Health Information (PHI) includes all confidential information which identifies you or could be used to identify you. The information may relate to your treatment and care, diagnosis, or progress. This information may be written, in a computer file, or spoken, and it may be related to your past, present or future health, health care, or payment for that health care.

When you sign the Consent for the Use and Disclosure of Protected Health Information, you consent to LORALIE GRIGAS, MSW, LCSW, LCAS, SAE using and disclosing your Protected Health Information (PHI) for Treatment, Payment, and Healthcare Operations (TPO). Treatment means the provision, coordination, or management of healthcare and related services, including coordination and consultation with other providers. Payment includes activities to obtain reimbursement for services.

Disclosure LORALIE GRIGAS, MSW, LCSW, LCAS, SAE can make without your consent or authorization

Unless you object, LORALIE GRIGAS, MSW, LCSW, LCAS, SAE may disclose your PHI without your Consent or Authorization to those directly involved in your care, such as family members, or to others identified by you if the information is relevant to that person's involvement with you. In addition, in an emergency or if you are incapacitated, We may rely on professional judgment as to information to disclose. For example, if you should be in an accident and unable to speak for yourself, we may tell hospital personnel about medications you are taking.

You have the right to request a limit on the health information LORALIE GRIGAS, MSW, LCSW, LCAS, SAE uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information LORALIE GRIGAS, MSW, LCSW, LCAS, SAE discloses about you to someone who is involved in your care. To request restrictions, make your request in writing, telling me (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) to whom you want the limit to apply. You may make this request when you sign the Consent for the Use and Disclosure of PHI or at any time in the future. Note: LORALIE GRIGAS, MSW, LCSW, LCAS, SAE is not required to agree to your request.

Disclosures LORALIE GRIGAS, MSW, LCSW, LCAS, SAE can make without your consent, authorization, or notice

There are certain other uses and disclosures of your PHI LORALIE GRIGAS, MSW, LCSW, LCAS, SAE can make without your consent, authorization, or notice. These include disclosures required by law, disclosures relevant to public health, including child abuse agencies, disclosures about victims of abuse, neglect or domestic violence, health oversight, for judicial and administrative proceedings when there is a court order, and under warrant or judicial subpoena *if* the information sought is relevant and material, the specific request is reasonably limited, and information which does not reveal your identity cannot reasonably be used.

Disclosure of Minimally Necessary Information

LORALIE GRIGAS, MSW, LCSW, LCAS, SAE will make reasonable efforts to limit individually identifiable health information to that which is minimally necessary to accomplish the intended purpose. All disclosures made under a specific authorization by you will be limited to the information you describe.

Right to inspect and request amendments to PHI

With few exceptions, you have the right to inspect your PHI which is contained in a "designated record set." This information includes your treatment and billing records or other information used in whole or in part to make decisions about your treatment and care. Information used for quality control or peer review analysis and not used to make decision about individuals is not in the designated record set.

Under certain conditions, access to the record may be denied. If this occurs, LORALIE GRIGAS, MSW, LCSW, LCAS, SAE will give the reason in writing and will give you access to other PHI to the extent possible. Reasons for denial include findings by a Licensed Health Care Professional determining the access requested is likely to endanger you or another person, is reasonably likely to cause harm to another person mentioned in the PHI, or that access by your personal representative is reasonably likely to cause harm to you or another person. LORALIE GRIGAS, MSW, LCSW, LCAS, SAE may also deny you access if the information was obtained from a non-health care provider under promise of confidentiality. You may contest any denial of access to your records.

You also have the right to request that LORALIE GRIGAS, MSW, LCSW, LCAS, SAE amend your record. This request must be in writing and must include your justification for the amendment.

If LORALIE GRIGAS, MSW, LCSW, LCAS, SAE agrees to your request, we will make the amendment and inform you that we have done so. LORALIE GRIGAS, MSW, LCSW, LCAS, SAE will also inform others who may have relied on the PHI. If another healthcare provider notifies me that they have amended the information they provided me, LORALIE GRIGAS, MSW, LCSW, LCAS, SAE will also make the amendment in our records.

LORALIE GRIGAS, MSW, LCSW, LCAS, SAE is not required to amend the record if the information is accurate and complete or if it was not created by LORALIE GRIGAS, MSW, LCSW, LCAS, SAE and the originator of the records is available. LORALIE GRIGAS, MSW, LCSW, LCAS, SAE is also not required to make the amendment if it is not part of the information kept by me or not information that you would be permitted to inspect.

We will usually respond to your request within 60 days, but can extend this period for an additional 30 days. If we deny your request, we will provide you, in writing, the basis for this denial. You can file a statement disagreeing with our decision, and you may request that we provide your statement with all future disclosures of your PHI. We may prepare a rebuttal to your statement, and will provide you with a copy of any such rebuttal.

Right to an accounting of disclosures

You have the right to request a list of disclosure that LORALIE GRIGAS, MSW, LCSW, LCAS, SAE have made to others, except those necessary to carry out health care treatment, payment or operations or disclosures we made to you. This request must be in writing and must state a time period for the accounting, which may not begin prior to April 14, 2003, and may not be longer than six years prior to the date you request the accounting.

Authorization to use or disclose PHI other than as discussed above

LORALIE GRIGAS, MSW, LCSW, LCAS, SAE will use or disclose your PHI in a manner not covered by this notice or by law only with your written authorization. This authorization must contain the specific information to be used or disclosed, the purpose of the use or disclosure, to whom the information is to be disclosed, and for what time period the authorization is valid. LORALIE GRIGAS, MSW, LCSW, LCAS, SAE will provide you with a copy of the authorization upon request. If we disclose your PHI under your authorization, there is the potential that the information will be subject to re-disclosure by the recipient and no longer protected by state or federal law. You may revoke the authorization in writing at any time except to the extent LORALIE GRIGAS, MSW, LCSW, LCAS, SAE have already acted upon it.

Right to change this notice

LORALIE GRIGAS, MSW, LCSW, LCAS, SAE reserves the right to change this notice at any time and to make the revised or changed notice effective for health information LORALIE GRIGAS, MSW, LCSW, LCAS, SAE has already have about you as well as any information we receive in the future. You may request a copy of the current notice at any time.