Jessica Manning, MSW, LCSW, LCAS
Seaside Counseling Services, PLLC
New Client Intake Form

Date: _____ Name: _____
(Last) (First) (MI) (Preferred Name)

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

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

Okay to leave message? ____ Yes ____ No Okay to text? ____ Yes ____ No

Email address: _____ Okay to contact via email? ____ Yes ____ No

SS #: _____-_____-_____ Birth Date: _____ Age: _____ Gender: ____ Male ____ Female

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

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

Marital Status: _____ Highest Level of Education Completed: _____

Employment Status: ____Full-Time ____Part-Time ____ Unemployed ____Student ____ Disabled ____ Retired

Primary care provider: *(Name)* _____ *(Phone)* _____

Current Medications: *(Name)* _____ *(Dosage/Frequency)* _____

(Name) _____ *(Dosage/Frequency)* _____

(Name) _____ *(Dosage/Frequency)* _____

(Name) _____ *(Dosage/Frequency)* _____

(Name) _____ *(Dosage/Frequency)* _____

Referred by: _____

Previous counseling? ____ Yes ____ No With whom? _____ When? _____

What is happening in your life that led you to make this appointment? _____

_____

What would you like to get out of therapy? _____

Insurance Information

Primary Insurance: _____ Policy #: _____

Group #: _____ Primary Insurance Phone #: _____

Subscriber's Name: _____ DOB: _____ Relationship to Client: _____

Secondary Insurance: _____ Policy #: _____

Group #: _____ Primary Insurance Phone #: _____

Subscriber's Name: _____ DOB: _____ Relationship to Client: _____

Jessica Manning, MSW, LCSW, LCAS
Seaside Counseling Services, PLLC
Office Policy/Consent to Treatment

Please read and sign below. Signature is 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 $25.00 fee will be charged 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 $25.00 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 and/or responsible party. Separate court fees will be charged if Seaside Counseling Services, PLLC and/or Jessica Manning, MSW, LCSW, LCAS is served with a subpoena for an appearance in person or a deposition subpoena for appearance to court. Requests for those fee 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 Jessica Manning, LCSW, LCAS.
2. I assign and authorize direct payments of all benefits due for client services to Seaside Counseling Services, PLLC and/or Jessica Manning, MSW, LCSW, LCAS. 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 Jessica Manning, LCSW, LCAS. 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

CONSENT FOR THE USE OF PROTECTED HEALTH INFORMATION

Under Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA), Jessica Manning, MSW, LCSW, LCAS 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, I may disclose PHI without your expressed consent under certain conditions. For certain statistical report and research purposes, I may also provide information about a group of clients which does not include any information which identifies you individually.

Jessica Manning, MSW, LCSW, LCAS's 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 Jessica Manning, MSW, LCSW, LCAS to use my PHI as described above and in the Notice of Privacy Practices.

This consent is truly voluntary. I understand that I may provide written notice to Jessica Manning, MSW, LCSW, LCAS 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 Jessica Manning, MSW, LCSW, LCAS's Notice of Privacy Practices. I also understand that Jessica Manning, MSW, LCSW, LCAS reserves the right to change or amend its privacy practices.

_____ _____

Client Signature Date

_____ _____

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

_____ _____

Witness Signature Date

Jessica Manning, MSW, LCSW, LCAS
Seaside Counseling Services, PLLC
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 the purpose 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

Please notify me 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 might 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.

_____	_____	_____
Client Signature	Client Printed Name	Date
_____	_____	_____
Guardian Signature	Guardian Printed Name	Date

Jessica Manning, MSW, LCSW, LCAS
Seaside Counseling Services, PLLC
Confidentiality/Client Rights/Grievances

Confidentiality in Behavioral Health Care Services

State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse or neglect, elder abuse or neglect, or dependent adult abuse or neglect. Abuse includes physical abuse, sexual abuse, and emotional abuse.
2. A situation in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. If you are required to sign a release of confidential information by your medical insurance.
5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies.
6. Patients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept by the therapist from others involved in your treatment.
7. I may at times speak with professional colleagues about our work without asking permission, but your identity will be disguised.
8. Patients under 18 do not have full confidentiality from their parents.

Client Rights for Behavioral Health Care Services

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 Jessica Manning, MSW, LCSW, LCAS & Carolina Beach Counseling.

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 Seaside Counseling Services, PLLC, Clinical Director at 1328 N. Lake Park Blvd., Suite 109, Carolina beach, NC 28428; phone 910-632-0994; fax 910-458-4824. **For grievances & complaints for Medicaid clients, call Trillium Health Resources Customer Service at 1-855-250-1539**. 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)

North Carolina Substance Abuse Professional Practice Board
www.ncsappb.org
P.O. Box 10126 Raleigh, NC 27605
Ph: 919-832-0975 Fax: 919-833-5743
Barden Culbreth, Executive Director

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

Your signature below indicates that you have fully read and understand the terms of confidentiality and your rights as a behavioral healthcare recipient.

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

_____ _____
Signature of Client or Legal Representative Date

_____
Printed Name of Client

_____ _____
Signature of Witness 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 JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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.

Disclosures JESSICA MANNING, MSW, LCSW, LCAS can make without your consent or authorization

Unless you object, JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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 JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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 JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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: JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC is not required to agree to your request.

Disclosures JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC can make without your consent, authorization, or notice

There are certain other uses and disclosures of your PHI JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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

JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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, JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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. JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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 JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC amend your record. This request must be in writing and must include your justification for the amendment.

If JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC agrees to your request, we will make the amendment and inform you that we have done so. JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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, JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC will also make the amendment in our records.

JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC is not required to amend the record if the information is accurate and complete or if it was not created by JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC and the originator of the records is available. JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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 JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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

JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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. JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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 JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC have already acted upon it.

Right to change this notice

JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC reserves the right to change this notice at any time and to make the revised or changed notice effective for health information JESSICA MANNING, MSW, LCSW, LCAS & SEASIDE COUNSELING SERVICES, PLLC 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.