Creative Counseling & Learning Solutions, PLLC

NEW CLIENT INTAKE INFORMATION - FOR ADULTS

Client's name: _____Birthdate: _____ School/Daycare/Work: _____
Parent/Guardian's name(s): _____ Address: _____
Home Phone #: _____Cell#:_____ Email: _____

Insurance Information

Carrier: _____ Policy# _____ Effective: _____
Policy holder: _____ Contact Info :_____

Religious and racial/ethnic identification:

Religious denomination/affiliation: _____ Involvement: _____
Name of Organization: _____
Ethnicity/national orign: _____ Race: _____

Medical Care Information

Clinic/doctor's name: _____ Phone: _____ Fax: _____
Address: _____ NPI: _____
If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ☐ Yes ☐ No

Consent to Use/Disclose Health Information: This agreement between you, _____and me Laura Greenhalgh, When the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:_____ . When I examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information".(PHI) about you .This information is needed to decide on what treatment is best for you and to provide treatment to you. This information may also be shared with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, I cannot treat you. In the future, we may change how to use and share your information, and so I may change the notice of privacy practices. If I do change it, you will be given a copy at that time. If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and cannot change that.

Signature of client or his or her personal representative _____Date_____
Printed name of client or personal representative_____ Relationship to client_____

Emergency information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call? Name: _____Phone:_____ Relationship:_____
Address: _____

Family-of-origin history

Relative Name	Current age (or age at death)	Illnesses (or cause of death if deceased)	Education	Occupation
Father:				
Mother:				
Brothers:				
Sisters:				
Stepparents:				
Grandparents:				

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History

Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/Diagnosis	Treatment Received	Treated by:	Result

Describe any allergies you have. _____
Reaction: _____ Allergy medications you take: _____

List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the-counter vitamins, supplements, herbs, and others.

Medication/Drug	Dose	Taken for -	Prescribed by -	For how long?

Psychiatric History

Please list all psychological/psychiatric care that you have received.

Age	Illness/Diagnosis	Treatment Received	Treated by:	Result

Checklist of Characteristics

Person completing this information: _____. This checklist contains concerns (as well as positive traits) that often describe what you may be experiencing. Feel free to add any others at the end under "Any other characteristics."

- ☐ Affectionate
- ☐ Complains
- ☐ Immature
- ☐ Easily Distracted
- ☐ Fearful
- ☐ Independent
- ☐ Moody
- ☐ Mute
- ☐ Obedient
- ☐ Recent move
- ☐ Self-harming
- ☐ Suicide concern
- ☐ Depression
- ☐ Arguementative
- ☐ Cries easily
- ☐ Dev. Delays
- ☐ Drug use
- ☐ Aggressive
- ☐ Impulsive
- ☐ Lack of respect
- ☐ Easily frustrated
- ☐ Obesity
- ☐ Poor relationships
- ☐ Speech difficulties
- ☐ Swears
- ☐ Work related issues
- ☐ Bullies/teases others
- ☐ Conflicts w/ others
- ☐ Fire setting
- ☐ Interrupts
- ☐ MR
- ☐ Nail biting
- ☐ Hyperactive
- ☐ Responsible
- ☐ Temper tantrums
- ☐ Nervous
- ☐ Anger Issues
- ☐ Runs away
- ☐ Shy
- ☐ Smoking
- ☐ Uncoordinated
- ☐ Concern for others
- ☐ Financial Concerns
- ☐ Academic concerns
- ☐ Hypochondriac
- ☐ Learning Disability
- ☐ Withdrawn
- ☐ Nightmares
- ☐ Intolerant of others
- ☐ Sad, unhappy
- ☐ Stubborn
- ☐ Medical Concerns
- ☐ Sexualized behavior
- ☐ Concern w/ living sit.
- ☐ Eating concerns
- ☐ Self-Esteem
- ☐ Tics
- ☐ Family Issues
- ☐ Underactive
- ☐ Anxiety
- ☐ Destructive
- ☐ Recent trauma
- ☐ Grief/Loss
- ☐ Sibling Concerns
- ☐ Manipulative/ Attention Seeking

Any other characteristics: _____

Which of these concerns do you want to be helped with most? _____

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Child Developmental History Record - Please fill in any information you have about your childhood development on the areas listed below.

Pregnancy and delivery: ☐ Unknown
Prenatal medical illnesses and health care: _____
Were you premature? _____ Weight and height at birth: _____ Any birth complications or problems?: _____

The first few months of life ☐ Unknown
Breast-fed? _____ If so, for how long? _____ Sleep patterns or problems: _____ Personality: _____

Milestones: At what age did you do each of these? ☐ Unknown
Sat without support: _____ Crawled: _____ Walked without holding on: _____ Helped when being dressed:_____
Ate with a fork:_____ Stayed dry all day: _____ Stayed dry all night: _____ Tied shoelaces: _____ Buttoned buttons: _____

Speech/language development ☐ Unknown
Age when you said first word understandable to a stranger: _____ First sentence? _____ Speech/hearing/language difficulties? _____

Educational History (include schools attended, services acquired, and any other relevant information): _____
_____
_____

Residences- Last 3

Address	From	To	With Whom	Reason for moving	Foster Care Placement?	Reason for Placement

Personal Strengths: _____
Personal Challenges: _____
Special skills or talents : _____
Special interests/hobbies: _____
Other: _____

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?
_____

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Intake Summary and Case Formulation

A. Basic information

Client: _____Date: _____ ID #: _____

Purpose of this intake: _____

B. Dynamics of difficulties

Presenting complaint(s):_____

Thoughts, behaviors, emotions _____

Stressors _____

Acute/chronic Strengths/resources_____

C. Assessment conclusions

1. Assessment of currently known **risk factors**:

Suicide:_____ *Homicide*:_____ *Impulse control*: _____

Adherence to treatments:_____ *Substance abuse/dependence*:_____

Current physical or sexual abuse: _____ Legally reportable? ☐ Yes ☐ No

Current child/elder neglect: _____ Legally reportable? ☐ Yes ☐ No

If risk exist, client ☐ can ☐ cannot meaningfully agree to a contract not to harm ☐ self ☐ others ☐ both

2. **Urgency** estimate ☐ Emergency; immediate interventions ☐ Serious disruption of functioning; act in next 24 hours
☐ Treatment needed; act soon/routine ☐ Wait for: _____

3. **Diagnoses**— Axis I: _____ _____ _____ _____ Axis II: _____ _____

Axis III—Significant and relevant medical conditions, including allergies and drug sensitivities:

1._____ 2._____ 3._____

Axis IV—Psychosocial and environmental problems in last year; overall severity rating:

☐ Problems with primary support group ☐ Problems related to the social environment
☐ Educational problems ☐ Occupational problems ☐ Housing problems ☐ Economic problems
☐ Health care access problems ☐ Problems related to legal system ☐ Other: _____

Axis V—(GAF) _____ **V Codes**— _____

D. Mental Status Exam:

Mood: _____ Affect:_____ Mental Status: _____

I have reviewed history with consumer and determined that the client is ☐ appropriate ☐ inappropriate for services.

_____ _____

Clinician's Name Date

E. Recommended program of coordinated liaisons, consultations, evaluations, and services

1. Psychotherapy: ☐ CBT ☐ TFCBT ☐ Behavioral ☐ Family ☐ Play therapy ☐ Group therapy ☐ Equine
2. Support groups: ☐ AA ☐ NA ☐ Parenting skills ☐ Communication skills ☐ Stress management
3. Legal services: ☐ Offender program ☐ Substance abuse/dependence ☐ Victim support

4. **Referrals for continuing services**

Referred to _____For (kind of service) _____ Date _____

I have assessed that client is appropriate for the above listed referred services

_____ _____

Clinician's Name Date

Creative Counseling & Learning Solutions, PLLC

Request/Authorization to Release Confidential Records and Information

I hereby authorize the release of information from my records to/from _____ (address): _____ (phone): _____ to/from _____Address: _____Phone: _____for the following purposes ☐ Further mental health evaluation, treatment, or care ☐ Rehabilitation Program ☐ Treatment Planning ☐ Research ☐ Court proceedings ☐ Other: _____. These records concern the time between _____ and _____.

Please select the information to be disclosed: ☐ Intake and discharge summaries ☐ Medical history & evaluations ☐ Mental health evaluations ☐ Developmental history ☐ Educational records ☐ Progress notes, treatment or closing summary ☐ Other: _____.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless directed here: ☐ Do NOT release HIV-related information ☐ Do NOT release drug and alcohol information

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of the release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

Client's Signature: _____ Printed name: _____

If Client is a Minor, Parent's/Guardian's Signature: _____

Printed name of Parent/Guardian: _____ Date: _____

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Client's Signature: _____ Printed name: _____

If Client is a Minor, Parent's/Guardian's Signature: _____

Printed name of Parent/Guardian: _____ Date: _____

Creative Counseling & Learning Solutions, PLLC
Professional Disclosure Statement
Laura M. Greenhalgh; LPC, NCC, NCSC

Introduction

I believe that counseling is a unique experience which is personal and created with the foundation of trust. To enhance you build this trust, I want to share with you my professional beliefs, background, and most importantly, your rights. This document is part of the standards of practice of the North Carolina Board of Licensed Professional Counselors. Please read this statement prior to our first session.

Philosophy and Approach

My approach to counseling could be best described as client centered, strength based, and solution focused. I believe that counseling is a joint effort, which is only successful with your hard work, energy, and courage. I encourage an enhanced sense of self understanding and acceptance of how past experiences have shaped the way we understand and relate to others, as well as how we view ourselves. Therapy provides a safe place to explore thoughts, reactions, and feelings about people in your life, as well as yourself. Therapy provides the opportunity to practice new ways of interacting in ones relationships with others. I believe that given the right support, and the tools for change, all people are capable of obtaining their best potential. The counseling goals and therapeutic techniques will be individually based, according to each client's individual concern, and their reasons for beginning the counseling process. I facilitate an approach to counseling children, adolescents, individual adults, and families, which is centered with a situational and developmental understanding, can include a variety of creative techniques (including art therapy, animal-assisted therapy, or play therapy), and is cognitive-behaviorally based (including the trauma focused cognitive-behavioral therapy which some clients may be receiving). I also believe in collaborating with other community resources, as appropriate, in order to better holistically support the well being of the clients that I serve.

The length of time that an individual receives counseling services is dependent on the reason for counseling. Together, we will decide on the number of sessions needed in order to achieve the therapeutic goals that are chosen. A referral to a medical doctor may be made, at any point in the counseling process, to rule out any possible biological causes for your distress. In the case of issues that are beyond my scope of competence, I will make appropriate referrals to appropriately qualified professionals.

I may recommend that some clients join a therapy group to maximize their growth potential. If you are referred to a group, all of the specifics of the process will be explained in detail before you are expected to make a choice to join or not. I believe that growth not only occurs in the counseling office, but outside of it as well. For this reason, I may choose to make referrals to support groups, or assign homework to encourage a more holistic support system for a client.

For the best interest of each client and to protect your personal rights, it is important to remember that our relationship must remain professional at all times. The therapeutic relationship often may seem very intimate, as a lot of personal information and deep feelings are often shared, it is therefore important to remember that my purpose of working with you is strictly professional.

Formal Training and Education

I hold a Master's Degree in Community Counseling from the University of North Carolina at Greensboro (Degree received May 2007). Within this program, the coursework and supervised practice emphasized counseling with children, adolescents, individual adult counseling, couples therapy, family therapy, and creative therapy. I am further certified in Equine-Assisted Psychotherapy through EAGALA. I have extended training and experience in working with foster care and adoption issues, sexuality issues, childhood trauma, Post Traumatic Stress Disorder, grief work, parenting training, and family issues. I hold my license for Professional Counseling (LPC) in the state of North Carolina (LPC#7373) and am a Nationally Certified Counselor (NCC#226064) I abide by the Code of Ethics of the North Carolina Board of Licensed Professional Counselors, and receive annual training on confidentiality and ethics for the profession of Counseling. I continue my education as a Professional Counselor through workshops, conferences, and classes working toward my PhD in Psychology, as I believe it allows me to offer the best possible practices for my clients if I stay on top of new information and techniques that may be helpful to them.

Fees

My fees are $150 for the initial intake session (90 minutes), $90 for individual and family sessions (50 minutes), and $50 per hour group session (50 minutes), per group member. I am also available for consultation and educational purposes (such as with the school system, community organizations, and etc.), and for these services, the individual session rate, per hour, plus mileage fees, apply. A sliding scale is available for clients meeting the annual financial requirement of $20,000 per year for individuals or $35,000 for a family of two or more. This will provide a discount of my regular fees to a percentage of the amount that is more affordable for the client. Cash and Check payments are accepted for all services rendered. *For returned checks, there will be a $25 charge added to your bill* to cover appropriate banking charges. I do accept Medicaid insurance, CHAMPUS, I am PBH certified and am beginning the process of adding on other insurance options. **Appointment cancellation must be made at least 24 hours prior to the time of the appointment to avoid being charged the full fee of the session.**

Sliding Scale Formula	Annual Income (Individual)	Annual Income (family)	Intake/Individual/Group Rates
	20,000	35,000	140/80/45 per hour
	15,000	30,000	120/60/40 per hour
	10,000	25,000	100/40/25 per hour
	5,000	20,000	90/20/10 per hour
	Less than 5,000	less than 20,000	70/10/5 per hour

Office Hours
Monday through Friday from 8am-6pm, unless otherwise agreed upon.

I am a community based therapist, which means that there is not an actual "office" in which I provide therapy. I take my services to the client. It may be their home, school, church, daycare facility, or a local meeting place that is appropriate for therapy.

Confidentiality
All information shared will be kept confidential with the following exceptions

* If I believe you are a danger to yourself or to someone else
* In the case of abuse to an elderly person or a child, confidentiality will be waived
* In case of a medical emergency
* If you give me written permission to disclose information
* If the information is court ordered
* If you desire to seek reimbursement from a managed care company, the disclosure of confidential information may be required for reimbursement
* These rights are waived if accusations of misconduct are brought

Even under the above circumstances, only the essential information will be revealed and I will attempt to inform you before confidentiality is broken. In the event that the client is a minor, the parents or legal guardians may be included in the counseling process as deemed appropriate, however, measures will be taken to safeguard confidentiality, to ensure the best interest of the client.

Client Rights
All client records are my professional property; however, they are kept on file for your benefit and are available to you at your written request, if deemed therapeutically valuable. As previously stated, you have the right to be informed of your therapist's qualifications as well as the right to accept or decline any suggestions or therapeutic strategies. I will remind you of these rights on a periodical basis. Termination of the counseling relationship will be made by you or by a decision made collaboratively between us both.

For disability-based assistance, please contact the Disability Rights of NC at (877)235-4210 or (919)856-2195; Fax: (919)856-2244; Email: info@disabilityrightsnc.org; Address: 2626 Glenwood Avenue, Suite 550 Raleigh, NC 27608

Emergencies
If you have an emergency, which you feel needs to be addressed immediately, please contact me at (704)322-1143. If I cannot immediately answer, please leave a detailed voice mail explaining the emergency on the confidential voice mail box and I will return your call in a timely manner based on the urgency of your concern. If I do not return your call within a few minutes time, please call 911.

Complaints
If at any time, you feel my counseling approach or my behavior is inappropriate or troubling you, please let me know. I will address your concerns in a timely manner. However, if you feel as though your concerns are not being addressed appropriately, please feel free to contact your medical insurance company or the North Carolina Board of Licensed Professional Counselors.

North Carolina Board of Licensed Professional Counselors
PO Box 1369 Garner, NC 27529-1369
(919) 661-0820 Fax: (919) 779-5642

Client Responsibilities
Clients have the responsibility to set and keep their appointments. If you are unable to keep an appointment, let me know as soon as possible, with at least 24 hours notice. Fees are expected to be paid at the time services are rendered. Treatment goals are planned by a collaborative effort of the counselor and the client, and the client is expected to follow through with the agreed upon goals as discussed. If at any time the client refuses treatment or does not follow the instructions of therapy, the client is solely responsible for his/her actions. The client is responsible for being considerate of the rights of other clients and of the counselor. The client is responsible for upholding the confidentiality of other client's mental health information which may be discussed during group therapy and socialization. Finally, it is the client's responsibility for keeping me accurately informed of progress towards meeting treatment goals and to terminate the counseling relationship before entering into an agreement with another counselor.

Consent for Treatment
By signing below, you are indicating that you have read this disclosure, and that you have understood all of the information provided to you. You have been informed that therapy is not guaranteed and of alternative method of treatment options available to you. Your signature also indicates that you are giving your consent to receive counseling services. Your consent can be revoked at anytime per your request.

_____ _____ _____
Client Name Client/Parent or Guardian Signature Date

_____ _____
Counselor's signature Date

Creative Counseling & Learning Solutions; PLLC

Financial Responsibility Statement

Date: _____

I, _____, understand that _____ will be

providing the fee based services identified below for myself and/or my family:

Outpatient Individual and Family Therapy

Frequency: 1 -2 x per week

Duration: 8-24 weeks

Average Cost: $90/hour

Your insurance will cover: $_____ per session

Your responsibility will be: $ _____ per session

Your copay will be : $ _____ per session due at time of services rendered.

Sliding scale fee agreed upon: $_____ per session due at time of services rendered unless prior arrangements are made.

I am aware of and agree to the following:

1. I know and understand that _____ provides a fee based service.
2. I will provide all needed health insurance/payment information for fee based services.
3. I will take all necessary steps to insure that all health insurances remain active and up to date.
4. It is my responsibility to maintain health insurance coverage.
5. I will be responsible for the payment of services provided if I allow my insurance to lapes.
6. If I request additional services beyond what my insurance has approved, such as case management (linkage, referral, etc.), court appearances, online, email, or text correspondence, work related documentation, etc., I agree to pay out of pocket expenses equal to $25/per 15 minutes of clinician work time.
7. I will be responsible for payment of $20.00 if I miss a scheduled appointment without calling to reschedule at least 24 hours before the scheduled appointment time.

_____ _____

Responsible party signature Date

Creative Counseling & Learning Solutions; PLLC

PO Box 81 Badin, NC 28009
704-422-5964 704-422-5041 (fax)
Director email: lauraglpc@gmail.com

Service Order

☐ Initial Service Order Request ☐ Continuation of Services Request

I, _____ (Doctor, Psychologist, or Psychiatrist) refer the following individual: _____ (client's full name and birthdate) for Outpatient Mental Health Treatment with Creative Counseling & Learning Solutions, PLLC.

Counseling Services Requested:
☐ Individual Therapy ☐ Family Therapy ☐ Group Therapy (if appropriate)

Referral Source Information

Name: _____ Profession: _____

Address: _____

NPI# _____

Office Number: _____ Fax Number: _____

Signature: _____ Date: _____

Other Agencies & Individuals Involved in this Referral:

☐ The Department of Social Services: _____
☐ School System: _____
☐ Court System: _____
☐ Parent/Guardian: _____
☐ Other: _____