CLIENT INFORMATION SHEET

Lifescapes Counseling Associates, PLLC

NAME: _____

CHART NO:
Intake Date:

PHONE: Daytime: _____ *OK to leave message? Y N*
Evening: _____ *OK to leave message? Y N*
Other: _____ *OK to leave message? Y N*

Dx Code:
Clinician:

ADDRESS: _____
_____
_____

BIRTH DATE: _____
SS#: _____
GENDER ID: _____ **SEX:** *M F*

MARITAL STATUS: ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed* ☐ *Domestic Partnership*

EMPLOYMENT STATUS: ☐ *Full-Time* ☐ *Part-Time* ☐ *Student* ☐ *Unemployed* ☐ *Retired* ☐ *Disabled/unable to work*

PLACE OF WORK: _____
POSITION: _____

ETHNICITY: _____
YEARS OF EDUCATION: _____

RESPONSIBLE PARTY: _____
ADDRESS: _____
_____

HOME PHONE: _____
WORK PHONE: _____

REFERRED BY: _____

COMMUNICATION PREFERENCES

With whom may we share information about:

1. APPOINTMENT SCHEDULING: ☐ *Spouse* ☐ *Child* ☐ *Parent* ☐ *Other*
Name: _____ _____ _____ _____

2. BILLING OR INSURANCE ISSUES: ☐ *Spouse* ☐ *Child* ☐ *Parent* ☐ *Other*
Name: _____ _____ _____ _____

3. TREATMENT, CLINICAL, DIAGNOSTIC INFORMATION RELATED TO YOUR THERAPY: ☐ *Spouse* ☐ *Child* ☐ *Parent* ☐ *Other*
Name: _____ _____ _____ _____

How would you prefer to receive appointment confirmations? ☐ *Text* ☐ *Phone* ☐ *Email*
_____ _____ _____

CONSENT FOR TREATMENT

I, the undersigned, have voluntarily applied for and agree to participate in counseling, psychological, &/or psychiatric services. I hereby authorize Lifescapes Counseling Associates, PLLC to release treatment and psychological information to my primary medical physician and health insurance carrier if necessary. I understand that I am fully responsible for all fees relating to my treatment which are not covered by my insurance plan, and I further agree to pay my co-payment at the time of each visit. ***In the event that I miss an appointment or cancel an appointment with less than 24 hours notification, I understand that I am solely responsible for paying a $60 fee. Furthermore, if I fail to appear for three consecutive scheduled appointments, my case may be placed on inactive status.***

_____ _____
Client signature Date

Lifescapes Counseling Associates, PLLC
950 Windy Rd, Suite 305
Apex, NC 27502

CONSENT & RELEASE FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Client giving Consent

Name: _____
Address: _____
Telephone: _____ Email: _____
Date of Birth: _____ SS#: _____

SECTION B: To the Client – Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This information may be disclosed via mail, fax, phone, direct communication, or electronic transmission.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our Privacy Officer. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____ _____
Signature of Client Date

If this Consent is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____
Relationship to Client: _____

❒ **REVOCATION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations (Please write explanation on the back of this form). I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

CLIENT CLINICAL INFORMATION - CHILD/ADOLESCENT (page 2)

CURRENT HOUSEHOLD / IMMEDIATE FAMILY: *Please list everyone who resides in your home, as well as other members of your immediate family not living at home. Include yourself in this listing. Include several "keywords" (quiet, angry, nurturing, etc…) to describe those listed below.*

NAME	*RELATION TO SELF*	*LIVING AT HOME?*	*AGE*	*SEX*	*KEYWORDS*
		Y N			
		Y N			
		Y N			
		Y N			
		Y N			
		Y N			
		Y N			

EDUCATION:

Does your child participate in any special eduation programs? **Y N**

Has your child been evaluated for ADHD or other learning disability? **Y N**

At school, is conduct/discipline a problem for your child? **Y N**

What is your child's estimated grade average? _____

List any school-based social or extracurricular activies in which your child participates: _____

LIFESTYLE: List any hobbies, pasttimes, or enjoyable activities in which your child regularly takes part:

SUPPORT SYSTEM: List all social and family sources of support (for instance, "sister, church, support group"):

What problems bring you in for counseling and how long have they been a concern?

What changes do you hope will be made as a result of counseling?

CLIENT INFORMATION SHEET - Child/Adol (page 2)

Below is a list of concerns people sometimes have. Consider each one and decide how much each one has bothered your child or has been a problem for your child during the past month:

	NONE 1	2	SOME 3	4	A LOT 5
Learning disabilities					
Other educational concerns					
Headaches					
Stomach problems					
Other health problems:					
list:					
Feeling depressed					
No appetite					
Difficulty sleeping					
Loss of energy					
Relationship concerns:					
With whom?					
Nightmares					
Weight loss					
Weight gain					
Suicidal thoughts					
Lack of friends					
Sexual concerns/behavior					
Legal involvement					
Self-esteem problems					

	NONE 1	2	SOME 3	4	A LOT 5
Family problems					
Over-activity					
Wetting or soiling self					
Anger					
Feeling inferior					
Oppositional behavior					
Speech problems					
Tantrums					
Anxiety, nervousness					
Withdrawn, isolated					
Self-control problems					
Violent behavior:					
By your child					
By someone else					
Misbehavior:					
Describe:					
Substance abuse:					
Describe:					
Destructive behavior:					
Describe:					
Other concerns:					
Describe:					

Does YOUR CHILD have a history of…

Substance abuse?		*Yes*		*No*
Abuse or trauma?		*Yes*		*No*
Criminal behavior?		*Yes*		*No*
Seizure?		*Yes*		*No*
Psychiatric hospitalization?		*Yes*		*No*
Suicide attempt?		*Yes*		*No*
Educational or learning problems?		*Yes*		*No*
Threatening or harming others?		*Yes*		*No*

Is there a FAMILY history of…

Mental illness?		*Yes*		*No*
Substance abuse?		*Yes*		*No*
Domestic violence or abuse?		*Yes*		*No*

How often does YOUR CHILD…

Smoke cigarettes (# packs/day) _____

Drink alcohol (# drinks/week) _____

Smoke marijuana (# times/mo.) _____

Use other drugs (# times/mo.) _____

Who is your child's primary care physician? _____

Please list any medications (& dosages) your child is taking: _____

_____

_____

Please list any chronic or serious medical problems: _____

_____

Please list any prior counseling experiences:

Name of agency or counselor: *Dates of service:* *Reason for counseling:*

_____

_____

_____

Lifescapes Counseling Associates, PLLC

950 Windy Rd, Suite 305
Apex, NC 27502

ATTENDANCE & CANCELLATION POLICY:

When you make an appointment with a therapist at our practice, we reserve that time especially for you. We do not overbook our appointments because we feel that our clients deserve to be seen in a timely manner. Just as you deserve your therapist's full attention during your appointment, we greatly appreciate knowing in advance when a client is unable to keep their appointment. When appointments are cancelled with less than 24 hours notice, it is almost impossible to fill that time slot with another client.

Also, please note that insurance companies do not pay benefits for missed and late-cancelled appointments. Therefore, missed appointments create a financial strain for our practice and make it difficult to serve the many clients on our waiting list. It is also important to note that consistency in attending counseling sessions is critical to effective counseling, and we want our clients to really benefit from our services.

For these reasons, your account will be charged a **$60** fee if you miss a scheduled appointment or cancel an appointment with less than 24 hours notice. Please let our office staff know if there is an extenuating circumstance preventing you from being able to keep your appointment (ie, illness, death in the family, etc…) as we certainly recognize that unexpected situations can arise.

FINANCIAL POLICY FOR MINOR CHILDREN OF SEPARATED/DIVORCED PARENTS:

It is our policy that the parent who consents to the treatment of a minor child is responsible for payment of services rendered. Neither Lifescapes Counseling Associates, PLLC, nor its contracted therapists will be involved with separation/divorce disputes. Divorced parents bear the responsibility for splitting the cost of therapy. The parent who brings a minor client to appointments is expected to pay the full copay due.

By signing below, I acknowledge understanding that Lifescapes Counseling Associates charges a $60 fee for no-shows and appointments cancelled with less than 24 hours' notice, and I acknowledge understanding of the client billing policy as it affects treatment of minor children with divorced/separated parents.

_____ _____

Signature of Client Date

_____ _____

Signature of Witness Date

Lifescapes Counseling Associates, PLLC

950 Windy Rd, Suite 305
Apex, NC 27502

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

You may refuse to sign this acknowledgement

On this date, I, _____ received a copy of the Lifescapes Counseling Associates, PLLC "Notice of Privacy Practices" to protect the privacy of my health information. I am aware that I may direct questions about our privacy practices to the Privacy Officer listed in the NPP.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❒ Individual refused to sign.
- ❒ Communications barriers prohibited obtaining acknowledgement.
- ❒ An emergency situation prevented us from obtaining acknowledgement.
- ❒ Other (Specify) _____
  _____
  _____

Lifescapes Counseling Associates, PLLC

Bradley Commons
950 Windy Road, Suite 305
919 303 0273

CREDIT CARD AUTOMATIC PAYMENT AGREEMENT

For your convenience, we offer our clients the option of arranging to pay all session fees and account balances with a credit card. With this arrangement, you do not have to spend additional time paying each time you come in. We accept Visa and Mastercard.

TransFirst (TSYS), our credit card processing vendor, will store your information on a secure and encrypted site, which will enable us to run bank card transactions through our computer system. Our employees will not have access to your bank card information within this system once it is entered. This form will be stored in a locked, secure location.

If you would like to take part in this voluntary payment arrangement, please complete the following information:

NAME OF PERSON RECEIVING TREATMENT: _____

FULL NAME PRINTED ON CARD: _____

CREDIT CARD ACCOUNT NO.: _____

EXPIRATION DATE: ____ /____ /____ SECURITY Code: _____

TYPE: Visa ❒ MC ❒ HSA ❒ HRA ❒

❒ I authorize LCA to charge the above credit card (or HSA/HRA card) for all account balances
❒ Since payment amounts may vary, I understand that I will receive email notification each time my credit card is charged. I will alert Lifescapes Counseling of any changes in my email address.
❒ This authorization is valid until I provide you with a written cancellation

AGREED (Signature): _____ DATE: _____