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Carolina Performance
FOR EXCELLENCE IN SPORTS, LIFE AND BUSINESS

New Client Intake Form

Name:_____ **Date:**_____

Mailing Address:

_____
_____
_____

Physical Address (if different):

_____
_____
_____

May I send mail to the above address? **Y / N**

Telephone Numbers (Please provide only numbers at which you give me permission to call you):

Home: _____ May leave a detailed message? ___yes ___*no

Work: _____ May leave a detailed message? ___yes ___*no

Cell: _____ May leave a detailed message? ___yes ___*no

Date of Birth/Age:_____ **Relationship Status:** _____

Student status/Occupation: _____

Have you ever engaged in therapy before? Y / N **Worked with a psychiatrist? Y / N**

Contact Person in case of emergency: _____
Telephone #:_____

Primary Care Physician:_____**Telephone#:**_____

Medical History:

- List any medical problems:

_____
_____
_____

- Current Medications:

_____
_____
_____

- Allergies:_____
- Hospitalizations (Medical, Psychiatric, Substance abuse- give place and year):

_____
_____
_____

- Family history of: mental illness? _____Yes _____No
- Substance abuse? _____Yes _____No
- Suicide? _____Yes _____No Violent behavior? _____Yes _____No

- How often do you?

Smoke _____never _____monthly _____weekly _____daily

Drink alcohol _____never _____monthly _____weekly _____daily

Use drugs _____never _____monthly _____weekly _____daily

Primary Insurance:

Insurance Plan Name:_____
Insured Name:_____ Insured ID#_____
Insured's social security #_____
Copayment:_____

How did you hear about our services? _____

_____

What would you like to gain from working with Carolina Performance? What are your goals?

_____

_____

_____

CONSENT FOR TREATMENT:

Your signature below indicates that you have read the Carolina Performance-Client Service Agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form.

_____ _____
Signature of Client (or Guardian if under 18) Date

_____ _____
Printed Name Provider Signature

RECORD RELEASE AUTHORIZATION:

I hereby authorize my Carolina Performance provider to furnish information to insurance carriers concerning my illness/treatment.

_____ _____
Signature of Client (or Guardian if under 18) Date

CREDIT CARD PAYMENT FOR PROFESSIONAL SERVICES

___ VISA ___ Mastercard

_____
Name on Account (exactly as it appears on credit card)

_____
Address (if different from the 1st page)

_____ _____
City ZIP Code

_____ _____ _____
Credit Card Number Exp. Date 3 Digit Security Code
(on the back of the card)

I authorize my Carolina Performance Provider to bill the above credit card for professional services.

_____ _____
Signature of Card Holder Date

PAYMENT FOR LATE CANCELLATION OR NO-SHOW

I authorize my Carolina Performance provider to bill the above credit card when I do not give advanced notice for a late cancellation or no-show, as per the "Carolina Performance – Client Agreement." I understand that if I do not wish my credit card billed for this purpose, I am still responsible for paying these fees.

_____ _____
Signature of Card Holder Date

Professional Disclosure Statement and

Consent for Professional Counseling Services

Darcee Ruble, M.Ed, LPC, LCAS

CAROLINA PERFORMANCE—CLIENT SERVICES AGREEMENT Welcome to Carolina Performance (CP). This document (the Agreement) contains important information about our professional services and business policies. Although Carolina. Performance providers work together with teams and businesses, we have separate, individual private practices in our offices at AIHF. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and heathcare operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between you and your provider. You may revoke this Agreement in writing at any time. That revocation will be binding on CP unless we have taken action in reliance on it; if there are obligations imposed on your CP provider by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Thank you for selecting me as your counselor. I believe the relationship between client and therapist is fundamental for growth and change in counseling and should be based on trust. With this in mind I would like to begin that relationship by telling you about my professional beliefs, experience and your rights. This is also in keeping with with Standards of Practice of the North Carolina Board of Licensed Professional Counselors (NCBLPC) and the North Carolina Substance Abuse Professional Practice Board (NCSAPPB). Please read this and make note of any questions or concerns you have at any time during our sessions.

Qualifications and Experience

I have been working in the helping field for over fourteen years and graduated from Providence College in Providence, Rhode Island in December 2003 with a Masters in Guidance and Counselor Education. Since 2001, while in graduate school, I worked as a substance abuse counselor at the Naval Ambulatory Care Center in Newport, RI. I moved to North Carolina in 2004 and worked as a substance abuse counselor, 2044 with an emphasis on case management. I was licensed in North Carolina as a Licensed Professional Counselor, 6627, in June 2007. I have also held the Licensed Chemical Addiction Specialist, 1613, from the North Carolina Substance Abuse Professional Practice Board since April 2010.

Counseling Philosophy and Approach

I believe that counseling works best when you and I work together as a team to develop goals that best meet your needs. Your progress towards these goals generally happens gradually over time and is enhanced by working on goals outside of therapy as well. Counseling interventions offer great potential for growth but can also cause uncomfortable emotions to arise. This is a normal part of therapy. You may experience any of the following as a result of our work: sadness, guilt, anger, frustration and anxiety. I emphasize that it is very important to explore these feelings in order to make progress towards your goals. As a result of counseling you can gain insight into your life, learn better methods of coping with problems, build self-confidence and have a more positive outlook in general. To sum it up counseling will be a joint effort but can only be successful with your work and determination.

Every person is unique with different strengths and needs. With this in mind I work with you to assess your mental, physical, social, economic and spiritual needs. Once the assessment is complete we will work together to develop a plan for you to achieve your goals. If necessary, I may refer you to your physician to rule out biological causes for your distress. In the case that your situation is beyond my scope of practice I will make every effort to refer you to

professionals more qualified to meet your needs. We have many wonderful psychiatrists and psychologists on staff at Carolina Performance if a referral needs to be made.

I am able to provide individual and group therapy as well as family psycho education for children, adolescents and adults. My counseling style is primarily motivational interviewing but strongly influenced by cognitive behavioral and reality therapy techniques. I am very sensitive to multicultural issues and can provide therapy in Spanish. Our sessions will focus on choices and how your choices affect your goals. If you agree, I may utilize homework assignments such as journaling that will be followed up in subsequent sessions. Above all you can expect me to treat you with respect and caring.

Confidentiality

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

a) If I believe you are a danger to yourself or someone else

b) If you give me written permission to disclose information

c) In the case of abuse to a child or an elderly person confidentiality will be waived

d) If the information is court ordered

e) If you desire to seek reimbursement from a managed care company, the disclosure of confidential information will be required for reimbursement or in the case I need to send information to a collection agency to recoup monies owed.

f) In case of medical emergency

g) If a government agency is requesting the information for health oversight activities, your provider may be required to provide it for them.

h) If a patient files a worker's compensation claim, and a CP provider's services are being compensated through workers compensation benefits, the CP provider must, upon appropriate request, provide a copy of the patient's record to the patient's employer or the North Carolina Industrial Commission.

i) If a patient files a complaint or lawsuit against CP, CP may disclose relevant information regarding that patient in order to defend CP. If a patient files a complaint or lawsuit against a CP provider, that provider may disclose relevant information regarding that patient in order to defend his or herself.

If one of the above circumstances arises only essential information will be revealed and if possible you will be informed before confidentiality is broken. In case the client is a minor; the parents or legal guardians may be involved in the counseling process when appropriate. Even when the guardian is involved precautions to safeguard confidentiality will be taken in order to have the best interest of the client foremost.

Federal law 42 CFR restricts the use and disclosure of patient information that is received by an alcohol and drug abuse treatment program. Generally, substance abuse information must not be disclosed without your written authorization. For example, I would need your written authorization before disclosing substance abuse information to your insurance provider for the purpose of obtaining reimbursement for service provided to you. Once a diagnosis is disclosed it is a permanent part of your insurance record.

Length of Sessions and Pay Schedule

Payment is expected at time of service. Forms of payment accepted are currently credit card, cash and check. There will be a 35.00 fee for all returned checks.

Each session will last 50 minutes. The standard fee for an intake is $165. The standard fee for an individual or family session is $135. If ADHD testing is required there is an additional charge of $15 per typed page in addition to the intake fee. I am in network with Blue Cross Blue Shield. At times telephone contact is necessary between a therapist and client for purposes other than scheduling sessions. Clients are responsible for payment of the agreed upon fee (on a prorated basis) for any telephone calls longer than five minutes. If you arrive late for an appointment, the appointment must end at the scheduled time. This will allow me to see each client as scheduled. Should you need to cancel or reschedule an appointment, it is requested that you do so with a 24 hour notice. Please call me at 919-810-0775 to cancel the appointment. If an appointment is cancelled or missed without a 24 hour notice, you will be billed your full therapy fee for the missed appointment.

Client Rights and Verification of Consumer Choice

All records are my property, however; they are maintained for your benefit and available for review at your request if they are deemed therapeutically valuable. You have the right to be informed of your counselor's qualifications and the right to accept or decline any suggestions or therapeutic strategies. I will periodically remind you of your rights. You have the right to terminate counseling or resend permission to disclose information at any time. It is suggested that termination be made collaboratively with client and counselor in order to ensure the best outcomes. You have the right to change service providers at any time, if possible, reasonable notice should be given so that I can aid the transition to your new provider.

Use of Diagnosis

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Emergencies

If you need to contact me please call 919-810-0775. Please note that I may not always be able to return your call immediately due to other commitments. In case of an urgent situation or emergency when you feel the need for immediate support contact the Alliance Behavioral Access 24/7 at 800-510-9132 or call Holly Hill Respond Line at 919-250-7000. You can also call local 911 system or go to the nearest emergency room.

Complaints

If at any time you feel uncomfortable or are dissatisfied with my services or counseling approach please let me know. Hopefully we can make changes to improve the situation. If you do not feel that your concerns are being addressed in a manner that you approve of please contact either of the following boards:

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

North Carolina Substance Abuse Professional Practice Board
PO box 10126
Raleigh, NC 27605
(919) 832-0975

Consent for Treatment

By signing below you are stating that you have read and understand this disclosure and that all your questions have been answered. That you agree to have your insurance charged and/or pay all fees. You have received a copy of

HIPAA regulations. It also indicates that you are consenting to receive counseling services.

Client Name	**Client/Parent/Guardian Signature**	**Date**

Darcee L. Ruble, M.Ed, LPC, LCAS	**Date**