

Client Demographic & Insurance Form

Name (First, Middle Initial, & Last Name), _____

Name You Prefer to be Called (if different from above), _____

Phone. Daytime: _____ OK to leave message?: Y N

Evening: _____ OK to leave message?: Y N

Other: _____ OK to leave message?: Y N

Address: _____ **Birth Date:** _____

_____ **Sex:** M F

_____ **SS#:** _____

Marital Status: Single Married Divorced Widowed In a committed relationship

Employment Status: Full-Time Part-Time Unemployed Retired Student

Place of Work: _____

Referred By: _____

Responsible Party: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

Insurance Information.

Insurance Company Name: _____ **ID Number:** _____

Claims Address: _____ **Group Number (or name):** _____

_____ **Policy Number:** _____

_____ **Authorization Number:** _____

Policy Holder Name: _____ **Date of Birth:** _____

Address: _____ **Home Phone:** _____

_____ **Work Phone:** _____

Are you under your employer's health plan? _____ **Employer:** _____

What is your relationship to the insured? _____

Consent for Treatment

Consent and Release for Use and Disclosure of Health Information

I, the undersigned have voluntarily applied for and agree to participate in counseling services from Beth D. Bowers Counseling, PLLC. I understand that I may revoke my consent for treatment at any time. I hereby authorize Beth D. Bowers Counseling, PLLC to release treatment and psychological information to my health insurance carrier for treatment, payment activities, and healthcare operations. I understand that I may revoke my consent to release treatment and psychological information to my health insurance carrier at any time.

Signature of Client or Parent/Guardian

Date

Signature of Witness

Date

Revocation of Consent for Treatment

I hereby revoke my Consent for Treatment. (Please write an explanation for this revocation on the back of this form.)

Signature of Client or Parent/Guardian

Date

Revocation of Consent and Release for Use and Disclosure of Health Information

I hereby revoke my Consent and Release for Use and Disclosure of Health Information for treatment, payment activities, and healthcare operations. (Please write an explanation for this revocation on the back of this form.) I understand that revocation of my Consent will not affect any action Beth D. Bowers Counseling, PLLC took in reliance on my Consent before receiving this written Notice of Revocation. I also understand that Beth Bowers, MSW, LCSW may decline to treat or continue to treat me after I have revoked my Consent.

Signature of Client or Parent/Guardian

Date

Attendance & Cancellation Policy

When you make an appointment with me, Beth D. Bowers, I reserve the time especially for you. Just as you deserve my full attention during your appointment, I greatly appreciate knowing in advance when you will be unable to keep your appointment. When appointments are canceled with less than 24 hours notice it is almost impossible to fill that time slot with another client.

*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 be aware that insurance companies do not pay for missed or canceled appointments & that you will be responsible for the entire **\$60** fee.*

*By signing below, I acknowledge understanding that Beth D. Bowers Counseling, PLLC charges a **\$60** fee for no-shows and appointments canceled with less than 24 hours notice.*

Signature of Client or Parent/Guardian

Date

Signature of Witness

Date

Informed Consent for Electronic Communications (E-mail, Texts, & Voice Mail)

Use of e-mail, texts, and/or voice mail as a means of correspondence involves a certain degree of risk to confidentiality. I am aware that although the computer used by Beth D. Bowers Counseling, PLLC utilizes additional security measures to ensure confidentiality, there remains a possibility that e-mail may be intercepted in transmission over the internet.

I am aware of these risks and I understand that these options for communication between myself and Beth D. Bowers, MSW, LCSW are available to me should I choose to use them.

Signature of Client or Parent/Guardian

Date

Financial Acceptance Form

YOU ARE EXPECTED TO PAY YOUR CO-PAY, DEDUCTIBLE, CO-INSURANCE, AND ANY PAST DUE BALANCE ON YOUR ACCOUNT AT THE TIME OF SERVICE.

The payment process for services at Beth D. Bowers Counseling, PLLC will be as convenient and easy as possible. You may pay by cash, check, Visa, MasterCard, or debit card. Please read the following and sign to accept these terms.

I, _____ agree to pay my co-pay, deductible,
(Client's Name, or Parent/Guardian Name)

co-insurance, and any past-due balance on my account at the time of service. I understand that I am fully responsible for all fees relating to my treatment which are not covered by my insurance plan.

Signature of Client or Parent/Guardian

Date

FOR YOUR EASE & CONVENIENCE, YOU MAY CHOOSE TO COMPLETE THE FOLLOWING TO AGREE TO KEEP A CREDIT OR DEBIT CARD ON FILE THAT WILL BE AUTOMATICALLY BILLED AT THE END OF EACH SESSION.

I, _____ would like to keep the following credit card
(Client's Name, or Parent/Guardian Name)

or debit card information on file and be automatically be billed at the end of each session.

Debit Card# _____ Expiration Date _____

Name on Card _____

Credit Card # _____ Expiration Date _____

Name on Card _____

Type of Card (Visa or MasterCard) _____

Three Digit Code (on the back) _____

Signature of Client or Parent/Guardian

Date

Notice of Privacy Practices – Brief Version

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.

My Commitment to Your Privacy

Beth D. Bowers Counseling, PLLC is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am required by law to keep your information private. This document covers the most common issues and questions regarding the privacy practices of Beth D. Bowers Counseling, PLLC, but does not cover all possible situations. Please talk with me about any specific questions or concerns. This document is a shorter version of the full, legally required "Notice of Privacy Practices" that you may request a copy of or access any time on the "Client Forms" page of Beth D. Bowers Counseling, PLLC, www.bethdbowerscounseling.com.

Beth D. Bowers Counseling, PLLC will use the information about your health which we get from you or from others, mainly to provide you with treatment, to arrange for payment for my services, and for some other business activities which are called, in the law, health care operations. After you have read this Notice of Privacy Practices you will be asked to sign a consent form to let Beth D. Bowers Counseling, PLLC use and share your information in an appropriate manner. If you do not consent and sign the form, I cannot treat you.

If you (the client) or this practice (Beth D. Bowers Counseling, PLLC) want to use or disclose (send, share, or release) your information for any other purposes, I (Beth Bowers) will discuss this with you and ask you to sign an authorization form allowing this specific release of information.

Of course Beth D. Bowers Counseling, PLLC will keep your health information private, but there are some instances when the law requires it to be used or shared. The most common examples of these exceptions are as follows:

- 1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. Beth D. Bowers Counseling, PLLC will only share information with a person or organization who is able to help prevent or reduce the threat.*
- 2. Some lawsuits and legal or court proceedings.*
- 3. If a law enforcement official requires me (Beth Bowers) to do so.*
- 4. For Workers Compensation and similar benefit programs.*

Your Rights Regarding Your Health Information

1. You can ask for communication about your health and related issues to take place in a particular way or at a certain place which is more private for you. For example, you can ask to be called at home, and not at work to schedule or to cancel an appointment. Every effort will be made to do as you ask.

2. You have the right to ask me (Beth Bowers) to limit what I tell people involved in your care or involved in the payment of your care, such as family members and your friends.

3. You have the right to look at the health information Beth D. Bowers Counseling, PLLC has about you, such as your medical and billing records, with the exception of psychotherapy notes. You can get a copy of these records, but you may be charged a fee for the copy.

4. If you believe the information in your records is incorrect or missing important information, you can ask that changes be made to amend your health information. You must make this request in writing, including the reasons you want to make the changes.

5. You have the right to a copy of this notice. If Beth D. Bowers Counseling, PLLC makes any changes to this Notice of Privacy Practices, you will be notified and supplied with an updated copy. You may always request a copy of the current Notice of Privacy Practices at any time.

6. You have a right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me (Beth Bowers) and with the Secretary of the US Department of Health and Human Services. All complaints should be made in writing. Filing a complaint will not change the healthcare provided for you in any way.

The effective date of this notice is February 14, 2011.

Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. These situations may be discussed with you now, or as they arise.

Acknowledgment of Receipt of "Notice of Privacy Practices"

You may refuse to sign this acknowledgment.

*On this date, I, _____ received a copy of and
(client name or name of parent/guardian printed here)*

*had adequate opportunity to review the "Notice of Privacy Practices" of Beth D. Bowers
Counseling, PLLC, as required by federal law to protect the privacy of my health
information.*

Signature of Client or Parent/Guardian

Date

Signature of Witness

Date

Emergency Disclosure Form

I, Beth Bowers, MSW, LCSW of Beth D. Bowers Counseling, PLLC do not provide emergency services, or have crisis coverage for urgent or emergency situations after office hours, and because I am not in my office five days a week, I need to inform you of the following.

- *I am usually, but not always, in this office on Monday, Wednesday, and Thursday. I will keep you informed of any changes in my schedule.*
- *At any time, you can leave voice mail messages for me, or speak with me if I am available at 368-5900. However, please be aware that I am not always available to answer the phone. Please leave a message and I will get back to you as soon as possible.*
- *In an emergency:*
 1. *Please go to your nearest hospital emergency room and ask for the psychiatrist on call or call 911 for transport to an emergency room.*
 2. *Residents of Wake County may choose to contact Wake County Crisis and Assessment Services. Crisis help is available for emergency situations 24 hours a day at 107 Sunnybrook Road, Raleigh, NC 27610, or by calling (919) 250-1260 or 1-877-626-1772.*
 3. *Please contact me when it is safe and convenient for you to do so, and let me know of your circumstances so that I may be of assistance to you.*
- *If you feel that your particular difficulties will lead to a need for after-hours or emergency services on a regular basis, you should consider seeking professional mental health services from a provider who can offer crisis coverage in addition to therapy. I will be happy to assist you with referrals for more appropriate or comprehensive services.*

Thank you for your understanding of my particular situation. This system generally works smoothly, and your needs will be well met. It is very important that we plan ahead and know what to do when extraordinary or urgent situations arise.

Signature of Client or Parent/Guardian

Date

Signature of Witness

Date

Client Clinical Information Sheet - Adult (page 1)

Below is a list of concerns people sometimes have. Consider each one, decide how much it has bothered you or been a problem for you during the past month, and then write a number (1 = a little bit, 2 = some, 3 = a lot) in the space next to any that apply to indicate how much of a concern it is.

- | | | |
|--|---|--|
| <input type="checkbox"/> Job related concerns | <input type="checkbox"/> Educational concerns | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Relationship concerns | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Health concerns | <input type="checkbox"/> Anxiety, nervousness | <input type="checkbox"/> Preoccupation with thoughts |
| <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Chronic worry | <input type="checkbox"/> Financial concerns |
| <input type="checkbox"/> Fear or phobia(s) | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Difficulty relaxing |
| <input type="checkbox"/> Identity concerns | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Parenting concerns |
| <input type="checkbox"/> Legal concerns | <input type="checkbox"/> Perfectionistic personality | <input type="checkbox"/> Family concerns |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Intrusive thoughts | <input type="checkbox"/> Feeling depressed |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Anger | <input type="checkbox"/> Feeling overwhelmed |
| <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Lack of enjoyment |
| <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Feeling isolated or withdrawn |
| <input type="checkbox"/> Self-control problems | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Fatigue or loss of energy |
| <input type="checkbox"/> Lack of friends | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Self-esteem issues |
| <input type="checkbox"/> Grief, loss, or mourning | <input type="checkbox"/> Overeating | <input type="checkbox"/> Lack of sexual interest |
| <input type="checkbox"/> Problems with trust | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Problems making decisions |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Poor motivation |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Feeling hopeless |
| <input type="checkbox"/> Avoiding people or places | <input type="checkbox"/> Over use of computer or internet | <input type="checkbox"/> Tearful, cry easily |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sick often | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Spiritual concerns | <input type="checkbox"/> Withdrawing | _____ |

Do you have a history of . . .

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

Is there a family history of . . .

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

Who is your primary care physician?

If yes, please complete the following brief substance use history to the best of your knowledge.

	Currently using	Method of use	Frequency of use	Amount	Age of first use
Cigarettes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
Other (specify):	_____	_____	_____	_____	_____
Other (specify):	_____	_____	_____	_____	_____
Other (specify):	_____	_____	_____	_____	_____

Client Clinical Information Sheet - Adult (page 2)

Current Household / Immediate Family / Key Persons: Please list everyone who resides in your home, as well as other members of your immediate family not living in your home, and other key persons in your life below. Include yourself in this listing. Choose several keywords (such as: quiet, angry, resentful, tired, nurturing, patient, trusting, etc.) to describe those listed below.

<u>First Name</u>	<u>Relation to You</u>	<u>Living at Home?</u>	<u>Age</u>	<u>Sex</u>	<u>Descriptive Keywords</u>
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	___	___	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	___	___	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	___	___	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	___	___	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	___	___	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	___	___	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	___	___	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	___	___	_____

Relationships: Are you currently in a committed relationship? Yes No
 If yes, what is your assessment of your current relationship? Good Fair Poor
 Have you previously been involved in committed relationships? Yes No
 If yes, how many times? _____
 How many times have you been married? _____
 Which of the following describe how you generally get along with others? (Check all that apply)
 Affectionate Aggressive Avoidant Fight or argue often Peacemaker Friendly
 Follower Leader Outgoing Shy or withdrawn Submissive Other: _____

Lifestyle: List any hobbies, pastimes, or enjoyable activities in which you regularly take part. _____

Spirituality/Religion: How important to you are spiritual/religious matters? None Some Moderate Much
 Would you like your spiritual/religious beliefs incorporated into your sessions here? Yes No

Support System: List all social and family sources of support (for instance; neighbor, church, support group, etc.):

Please list any medications (& dosages) you are taking. _____

Please list any chronic or serious medical problems. _____

Client Clinical Information Sheet - Adult (page 3)

Please list any prior counseling experiences:

Name of agency or counselor:

Dates of service:

Reason for counseling:

What problems bring you to counseling and how long have they been a concern? _____

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