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 a 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*

Financial Policy for Minor Children of Separated or Divorced Parents:

It is the policy of Beth D. Bowers Counseling, PLLC that the parent who consents to the treatment of a minor child is responsible for payment of the services rendered.

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, and I acknowledge understanding of the the client billing policy as it affects treatment of minor children with separated or divorced parents.

_____ _____

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 – Child/Adolescent (page 1)

*Below is a list of concerns people sometimes have. Consider each one, decide how much it has bothered your child or been a problem for your child 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.*

___*Learning disabilities*
___*Other educational concerns*
___*Headaches*
___*Stomach Problems*
___*Other health problems*
___ *Over use of computer,internet, cell phone, or other electronics*
___*Increased appetite*
___*Nightmares*
___*Suicidal thoughts*
___*Lack of friends*
___*Other concerns*
*describe:*_____

___*Family problems*
___*Wetting or soiling self*
___*Oppositional behavior*
___*Speech Problems*
___*Anxiety, nervousness*
___*Self-control problems*
___*No appetite*
___*Loss of energy*
___*Weight loss*
___*Weight gain*
___*Violent behavior by your child*
___*Destructive behavior*

___*Over-activity*
___*Anger*
___*Feeling inferior*
___*Tantrums*
___*Withdrawn, isolated*
___*Feeling depressed*
___*Difficulty sleeping*
___*Relationship concerns with whom?*_____
_____
___*Self-esteem problems*
___*Misbehavior*

Does your child have a history of . . .

Abuse or trauma? ☐ *Yes* ☐ *No*
Psychiatric hospitalization? ☐ *Yes* ☐ *No*
Threatening or harming others? ☐ *Yes* ☐ *No*
Criminal behavior? ☐ *Yes* ☐ *No*
Seizure? ☐ *Yes* ☐ *No*
Suicide attempt? ☐ *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 child's 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	☐ *Yes* ☐ *No*				
Alcohol	☐ *Yes* ☐ *No*				
Marijuana	☐ *Yes* ☐ *No*				
Other (specify):					
Other (specify):					
Other (specify):					

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

Please list any chronic or serious medical problems: _____
_____
_____

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 child's life below. Include yourself and your child in this listing. Choose several keywords (such as: quiet, angry, resentful, tired, nurturing, patient, trusting, etc.) to describe those listed below.*

First Name	*Relation to Client*	*Living at Home?*	*Age*	*Sex*	*Descriptive Keywords*
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			

Relationships: *Which of the following describe how your child generally gets along with others?* *(Check all that apply)*

☐ *Affectionate* ☐ *Aggressive* ☐ *Avoidant* ☐ *Fight or argue often* ☐ *Peacemaker* ☐ *Friendly*
☐ *Follower* ☐ *Leader* ☐ *Outgoing* ☐ *Shy or withdrawn* ☐ *Submissive* ☐ *Other:* _____

Education: *Where does your child attend school?* _____

Does your child participate in any special education programs? ☐ *Yes* ☐ *No*

Has your child been evaluated for ADD, ADHD or other learning disability? ☐ *Yes* ☐ *No*

At school, is conduct /discipline a problem for your child? ☐ *Yes* ☐ *No*

What are your child's current estimated grades/grade average? _____

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

_____

_____

_____

Spirituality/ Religion: *How important to you and your child are spiritual/religious matters?*

☐ *None* ☐ *Some* ☐ *Moderate* ☐ *Much*

Lifestyle: *List any hobbies, pastimes, or enjoyable activities in which your child regularly takes part:* _____

_____

_____

_____

_____

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

_____

_____

_____

_____

Client Clinical Information Sheet – Child/Adolescent (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?