
# Patient Intake Form

## Patient Information

Name: _____
Last Name First Name Initial

Social Security #_____

Address:_____

City:_____ State:_____ Zip: _____

Home Phone_____ Work/Mobile Phone_____

Sex M/F Age ____ Birth date: _____Single_ Married_ Widowed_ Separated_ Divorced_

Employer_____ Occupation:_____

School_____Grade_____

Referred By_____

Emergency Contact_____ Phone: (___) _____
_____

## Primary Insurance

Person Responsible for Account (Please Print)_____

Relationship to Patient_____ DOB_____

SS#_____

Address_____City_____

State_____Zip Code_____

Employer_____

Insurance Company_____

Insurance Group #_____

Insurance ID#_____

Insurance Phone(_____) _____

## Secondary Insurance

Secondary Insurance Company_____

Subscriber Name (Please Print)_____

Relationship to Patient_____

Address_____

City_____

State_____Zip Code_____

Employer_____

Insurance Company_____

Insurance Group #_____

Insurance ID#_____

Insurance Phone(_____) _____

## Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____
Name of insurance company(ies)

And assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize Zoe Counseling & Consulting to release all information necessary to secure payment of benefits, and authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

I give permission for treatment of myself/my dependent to Zoe Counseling & Consulting.

_____ _____ _____
Responsible Party Signature Relationship Date

Consumer Name_____ Insurance #_____

Record #_____ DOB_____ Date_____

# INFORMED CONSENT FORM

Welcome to Zoe Counseling & Consulting, PLLC. This document contains important information about our professional services and business policies. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.
Zoe Counseling & Consulting, PLLC provides services to individuals and/or families who may experience emotional, developmental, social, marital/couples, and substance abuse problems. Our therapists are trained to provide appropriate treatment as needed to help the individual and/or family.

While I expect benefits from treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed.

I understand that the therapist(s) are not providing emergency services and I have been informed of who/where to call in an emergency.

I understand that regular attendance will produce the maximum possible benefits but that I or my child are free to discontinue treatment at any time in accordance with the policies of the office.
I have been informed of the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threats of harm to myself or another person.

I am not aware of any reason why my child or I should not proceed with therapy and my child or I agree to participate fully and voluntarily.

I have had the opportunity to discuss all aspects of treatment fully, have had my questions answered, and understand the treatment planned. Therefore, I agree to comply with treatment and authorize Zoe Counseling & Consulting, PLLC to provide the treatment to my child or me.

I, _____authorize Zoe Counseling & Consulting, PLLC to contact individual and /or physician/hospital in the event that I become incapacitated due to an emergency illness or accident while in treatment.

| | |
|---|---|
| Name of Physician/Hospital: | |
| Telephone: | |
| Emergency Contact: | |
| Relationship: | |
| Telephone: | |

Consumer Name_____ Insurance #_____

Record #_____ DOB_____ Date_____

## Office Billing and Insurance Policy

I authorize use of this form on all my insurance submissions.
I authorize the release of information to my insurance company.
I understand that I am responsible for the full amount of my bill for services provided.
I authorize direct payment to my service provider.

Patient Signature (or guardian):_____ Date:_____

## Cancellation/No Show Policy

**There is a 24-hour cancellation policy**, which requires that you cancel your appointment **AT LEAST** 24 hours in advance. If special services* are required for the appointment, **there is a 48-hour cancellation policy**. Please be mindful that your service provider reserves the appointment time for you. If you are unable to make your appointment, please notify me, as I can use that time for another person in need. I will work with your schedule to provide you with another appointment. Three (3) no show/cancelled appointments with less than 24 hour notice may result in discharge of services from Zoe Counseling & Consulting, PLLC. Your service provider will work with you to find another provider that meets your needs. In addition, therapist reserves the right to charge a $25 charge** for no show or improperly cancelled appointments. Please be aware that your insurance company does not cover this fee.

## Contacting Your Counselor

I/We may often not be immediately available by telephone. I do not answer my phone when I/We are with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible, but it may take up to 24 hours for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I/We are unable to reach you, please give us another call. You may also email your counselor at zoe.counseling@yahoo.com I/We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional(s) covering our practice. IF YOU HAVE A MEDICAL EMERGENCY, PLEASE CALL 911 OR GO TO NEAREST EMERGENCY ROOM. IF YOU HAVE A BEHAVIORAL HEALTH EMERGENCY, PLEASE CONTACT THE AFTER HOURS LINE at **(980)989-4453**. (YOU MAY NEED TO LEAVE A MESSAGE AND YOUR CALL WILL BE RETURNED WITHIN THE HOUR). I offer appointments within 48 hours for urgent care needs.

Consumer Name_____ Insurance #_____

Record #_____ DOB_____ Date_____

## Your Client Rights

You have the right to be treated in a considerate, safe and respectful manner, without discrimination as to race, ethnicity, color, disability, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You may also request that I refer you to another therapist and are free to end therapy at anytime.

The North Carolina General Statutes and Administrative Code outlines rules and regulations about Consumer Rights. It is important that your rights are protected. It is important that your rights are not violated.

**Consumer rights include, but are not limited to**:

- You have the right to dignity, privacy, and humane care.
- You have the right to be free of mental abuse, physical abuse, neglect and exploitation.
- You have the right to treatment, regardless of your age or disability. The treatment you receive will be age appropriate.
- The right to receive information about the organization, its services, its practitioners/providers and member rights presented in a manner appropriate to the consumer's ability to understand.
- The right to participate with your provider in making decisions regarding health care, including the right to refuse treatment.
- You have the right to refuse treatment at any time. However, it is strongly encouraged that you discuss this with your provider.
- The right to a candid discussion with your provider of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. Clients may need to decide among relevant treatment options, the risks, benefits, and consequences, including their right to refuse treatment and to express their preferences about future treatment decisions regardless of benefit coverage limitation.
- The right to voice complaints or appeals about the organization or the care it provides.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- The right to request and receive a copy of his or her medical record, subject to therapeutic privilege, as set forth in NC G.S. 122C-53(d) and to request that the medical record be amended or corrected in accordance with 45 C.F.R. Part 164 and the provisions of NC G.S. 122C-53(d). If the doctor or therapist determines that this would be detrimental to the physical or mental well-being of the person, the person can request that the information be sent to a physician or professional of his/her choice.
- The right to participate in the development of a written person-centered treatment plan that builds on individual needs, strengths, and preferences. A treatment plan must be implemented within thirty (30) days of admission.
- The right to take part in the development and periodic review of a treatment plan and to consent to treatment goals in it.
- The right to freedom of speech and freedom of religious expression.
- The right to treatment in the most normal, age-appropriate and least restrictive environment possible.
- The right to make recommendations regarding the organization's member rights and responsibilities policy.
- Your care is confidential. Even the fact that you are receiving services is confidential. Information about you can only be shared when:
  1. You have given written consent.
  2. You have been ordered by a court of law.
  3. You become a danger to yourself or others and it is necessary for someone to submit involuntary commitment papers or find hospital placement for you.
  4. You are likely to commit a serious crime. Your provider will share the information with the appropriate law enforcement agency

What do I do if I want to file a complaint or grievance?
We encourage you to discuss your concerns directly with your provider. However, we are aware that there are times when issues cannot be resolved. Sometimes you may also feel that you are not able to discuss your concerns with your provider. If you would like to talk about your complaint or grievance with someone other than your provider, you can call:

- Disability Rights of North Carolina numbers are 1-877-235-4210 and 1-919-856-2195

Patient Signature (or guardian):_____ Date:_____

Name of Patient: _____ Date:_____

Patient/Guardian Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

*additional agreement needed
**this statement may not apply to all individuals.
***please see Electronic Communication Policy

Consumer Name_____ Insurance #_____

Record #_____ DOB_____ Date_____

## Confidentiality

**All sessions are confidential** and protected by the HIPAA law and my ethical standards through my board. There are some limits to confidentiality, such as reporting child or elder abuse, when you are in danger or hurting yourself or someone else or when the courts order your records. Otherwise, your information is confidential unless you ask me to share it with a third party. If this happens, the request will take place in writing. Special note on confidentiality with children and adolescents: Psychotherapy with people of any age relies on the client's confidence that what is shared with the therapist is private and confidential. While parents and guardians have the right to know general information about how the therapy with their child is progressing, in signing this form you waive the right to know the private details of the child's therapy or to have access to the confidential therapy records of the child. A general summary can be provided at any time upon request. I will check in with parents at the beginning of each session for an update or to address a concern. If there is an issue or concerns of great importance, I will encourage your child to share this information. Family therapy may be used to help facilitate a better communication environment with you and your child.

**Length of Session and Fees**

A therapy session can last anywhere from 45-75 minutes. We will schedule these sessions based on our mutual agreement. **If you are unable to keep an appointment, please give at least 24 hour notice as that time can be used for another person in need.** Appointments that are consistently missed or canceled can result in the termination of the therapy. An appropriate referral will be given to you if this occurs. I currently accept Medicare, private insurance/EAP and self-pay clients. If you have other insurance, you will be responsible for payment up front and receiving a reimbursement from your insurance company. A sliding scale can be used when with self-pay and other insurance clients.

**Complaint Procedures**

If you are dissatisfied with any aspect of this practice, please inform me immediately. I will work with you to resolve the matter. If you feel that this matter cannot be resolved with me, you can contact:

- Disability Rights of North Carolina numbers are 1-877-235-4210 and 1-919-856-2195
- North Carolina Board of License Professional Counselors at 844-622-3572
- Partners Behavioral Health Management at 1-888-235-HOPE (4673)
- North Carolina Social Work Certification and Licensure Board 336-625-1679

Thanks again for choosing Zoe Counseling & Consulting as your provider. If you have any questions or comments, please feel free to inform me.

Client/Guardian Signature_____ Date_____

Therapist Signature_____ Date_____

Consumer Name: _____Insurance #: _____

Record #: _____ DOB: _____ Date: _____

## AUTHORIZATION FOR RELEASE, DISCLOSURE, AND EXCHANGE OF INFORMATION

I (We) authorize Zoe Counseling & Consulting PLLC, 611 North Central Ave, NC 28012, to release, disclose, and exchange information from the clinical record of

Client Name_____ DOB_____

to and allow such information to be inspected and copied by

(Facility/Provider)_____

(Address)_____

(City)_____(State)_____(Zip)_____

Nature of information to be released, disclosed, and exchanged (State specific nature of information)_____

_____

For the purposes of (State specific purpose of information)_____

_____

Re-Disclosure: Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law (45 CFR Part 164) may not apply to the recipient of the information and, therefore, may not prohibit the recipient of the information from re-disclosing it. Other laws, however, may prohibit re-disclosure. When information Is released from this agency protected by state law (NCGS 122C), substance abuse treatment information protected by federal law (42 CFR, part 2)or state law (G.S.130A-143), HIV/AIDS information the recipient of the information is informed that re-disclosure is prohibited except as permitted or required by these laws. I understand that I may revoke this consent in writing at any time, except where action has already been initiated on this authorization.

This authorization is valid until _____ (not to exceed one year from date of signature)

I authorize release/disclosure of information which contains Substance Abuse Information: Yes___ No___

I authorize release/disclosure of information which contains HIV/AIDS information: Yes___ No___

I understand that signing this authorization is voluntary. Provision of services is not contingent upon consent and of the need for release

_____ _____

Client Signature Date Parent/Guardian Signature Date

_____ _____

Clinician Date Witness Date

Consumer Name_____ Insurance #_____

Record #_____ DOB_____ Date_____

## Written Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receipt of Zoe Counseling & Consulting Notice of Privacy Practices.

_____ _____

Client Name Guardian Name

_____ _____

Client or Guardian's Signature Relationship to Client

_____

Date

Consumer Name_____ Insurance #_____

Record #_____ DOB_____ Date_____

# Treatment Plan

**Client Name:**
**Recipient ID number:**
**Record number:**
**DOB:**

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**Diagnosis:**

**Presenting Problem 1:**
**Goal 1:**

**Interventions:**

**Start Date:** **End Date:** **Review Dates:**

**Presenting Problem 2:**
**Goal 2:**

**Interventions:**

**Start Date:** **End Date:** **Review Dates:**

**Presenting Problem 3:**
**Goal 3:**

**Interventions:**

**Start Date:** **End Date:** **Review Dates:**

_____ _____
**Client Signature** **Date**

_____ _____
**Parent/Guardian Signature** **Date**

_____ _____
**Clinician Signature** **Date**