Creating New Beginnings Counseling and Consulting, LLC
Dr. Candice Norris-Brown, LPC, NCC, ACS

Welcome and thank you for choosing CNB Counseling and Consulting Services for your child or young adult. This document is designed to answer some frequently asked questions regarding the counseling process, our professional relationship, confidentiality, and your financial obligation. As you read this, feel free to mark any places that are not clear to you or write in any questions that come to mind so we can discuss them. This will allow us to work most productively and comfortably together. An initial intake assessment will be completed within 60 minutes. This process includes a variety of questions about your presenting issues and background. At the end of the session, I will provide recommendations on how best to move forward. It will be helpful at that time for you and I to discuss and decide on the options and recommendations you want to pursue for your child or young adult. Subsequent counseling sessions will be 50 minutes in duration. Please note shortened or extended sessions can be arranged as needed by prior agreement.

Initials _____ Date _____

Initials _____ Date _____

INFORMED CONSENT
PLEASE INITIAL WHERE INDICATED, STATING YOU HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED.

Counseling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY

All interactions with Counseling Services, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate. The law protects the privacy of all communications between a client and a psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations in which I am legally obligated to take actions and I may have to reveal some information about your treatment. These situations are most unusual in our practice. However, I am required to report any evidence of child abuse, strong suspicions of child abuse and/or neglect. I am also mandated to report abuse of handicapped or elderly persons. If I determine that a client presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/ or contacting the police, and/or seeking hospitalization for the client. Finally, if in my judgment, I feel any person is a serious and immediate risk of harming him/herself I will break confidentially to ensure the safety of my client. I will notify other family members or the police in order to maintain safety. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

Initials _____ Initials _____

Emergencies

Due to my schedule, I am often not immediately available by phone, as I am usually with clients. Therefore, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call in the same day you make it, with the exception of weekends and holidays. If you feel that you cannot wait, please call 911 or go to the nearest Hospital Emergency Room for help. Please do not wait for me to contact you to utilize those resources. If I am going to be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Initials _____ Initials _____

Insurance

Creating New Beginnings Counseling only accepts certain insurances. Please confirm your insurance company with me prior to your first session if you will be utilizing your insurance benefits. Neglecting to do so means you will be responsible for paying the full amount of the session. Managed Health Care Plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. You should be aware that contact with your health insurance company may require that I release information relevant to the services I provide to you, including a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share information with a national medical information databank. I will provide you with a copy of any treatment plan I submit, if you request it. It may also be necessary to seek approval for more therapy after a certain number of sessions. Your signature allows me to submit a treatment plan to request further time or number of visits. By signing this Agreement, you agree that I can release requested information to your carrier. If you have concerns regarding confidentiality based on the above information, please feel free to discuss with me our private pay or sliding scale options. If I am considered an out-of-network provider for your insurance company you may seek reimbursement

from your insurance company by supplying them with invoices/superbills. These invoices/superbills include all the required information regarding your treatment. If you plan to file for reimbursement, please be aware that you will still be responsible for payment at the time of service and you are responsible for filing the claims with your insurance company.

Initials _____ Initials _____

Cancellation Policy

For cancellations occurring at least 24 hours prior to your appointment time, no charges will be incurred. For cancellations occurring less than 24 hours prior to your appointment time, you will be responsible for paying the $100 missed session fee. For appointments not kept (and not cancelled), you will also be responsible for paying the $100 missed session fee.

Initials _____ Initials _____

Payment and Returned Check Fee- Payment in full is due when services are rendered unless other arrangements have been made in advance. There is a $40 returned check fee in addition to the fee for service.

Initials _____ Initials _____

HIPAA

You have the right to obtain or review a summary about the Health Insurance Portability and Accountability Act (HIPAA), a 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 purposes of treatment, payment, and health care operations. If you have any questions about HIPAA, please let me know and I am happy to discuss any of these rights with you. The law requires that I obtain your signature acknowledging that I have given you the opportunity to review HIPAA regulations.

Initials _____ Initials _____

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the Counseling Services.

Signature of Client	*Signature of Therapist*
Date	

Patient Intake Information

Patient Name:	**Social Security #:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Email Address:	**Mobile Phone:**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about the practice?	**Marital Status:**

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	**Home Phone:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**
Relationship to Patient:	**Responsible Party SSN:**

Insurance Information

Primary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	**Policy Holder SSN:**
Secondary Insurance:	**Policy Holder Name:**

Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer/School:	**Policy Holder SSN:**

Reason for referral or reason you are seeking treatment.

_____
_____
_____

Recent significant events, changes or stressors in your life:

_____
_____
_____

Previous therapy? When and did you find it helpful?

_____
_____
_____

List any significant health problems, mental illness, or recent death of family members.

_____
_____
_____

Physician Name and Current medications

_____
_____
_____

Patient Communication Preferences

Our office may need to contact you to schedule and/or reschedule appointments, to schedule follow-up visits and other such administrative issues. To ensure that your privacy is maintained to the fullest extent possible, please select the method by which our office can contact you.

Client Name_____

Parent/Guardian _____ Parent/Guardian_____

Preferences for Parent Guardian (1)

Home phone- Leave message? Yes_____ No_____

Cell phone- Leave message? Yes_____ No_____

Work phone- Home email Yes_____ No_____ Work e-mail Yes____ No____

Preferences for Parent/Guardian (2)

Home phone- Leave message? Yes_____ No_____

Cell phone- Leave message? Yes_____ No_____

Work phone- Home email Yes_____ No_____ Work e-mail Yes____ No____

Signature:_____ Signature:_____
Date:_____ Date:_____