Inner Light Counseling PLLC

Lissa Carter, MA, NCC, LCMHCS, LCAS

Client Information Form

Today's Date: ________________________

Your Name:____

Preferred Name and Pronouns: ____

Address _____________________________ City _______________ State _______ Zip _________

E-mail: ____

Preferred Phone:____

Age: _________________________ Date of Birth:_______________________________

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

If I must cancel your appointment or reach you urgently, how should I contact you?

☐ Home ☐ Work ☐ Cell ☐ E-mail ☐ None

Employer:________________________________ Occupation:________________________________

Why are you seeking counseling?

____

Have you had counseling in the past?_______ If so, what worked for you?

____

What didn't work?

____

How were you referred to my office?

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____

YOUR EDUCATIONAL GOALS

Are you currently attending school, and if so, what are you studying?
____

Did you attend college?_____ When, where?____

Do you have any plans to further your education? __________ If so, when and what?
____

YOUR PHYSICAL HEALTH

Do you have a doctor? ________________

If you would like me to consult with your doctor, please provide their contact information below:
____

Do you have any current health concerns?
____

Describe any allergies you have:
____

Do you have any chronic medical concerns? ________Please list: ______________________________

Do you have a current mental health diagnosis? If so, which one? Do you believe it is accurate?
____

Are you under the care of a psychiatrist? If so, whom? If you would like me to consult with your psychiatrist, please provide their contact information below: ____

____

Have you been prescribed any psychotropic drugs by your Psychiatrist? ☐ Yes ☐ No

Please list all medications or drugs (prescription or self-medication) you have taken in the last year (this information is completely confidential):
____

Please list any diseases, illnesses, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and any other medical condition you have experienced in the past few years:
____

____

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YOUR EMOTIONAL HEALTH

Please describe any major breakups, family discord, trauma, grief, or other stress you have experienced in the past few years:

____

____

____

What else do I need to know about you to be an effective and respectful counselor?
____

____

Professional Disclosure Statement and Informed Consent

PLEASE INITIAL EACH ITEM:
______ I understand that Lissa Carter, MA, LCMHCS, LCAS is a Licensed Clinical Mental Health Counselor in the state of North Carolina.

______ I understand that Lissa Carter does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.

______ I understand that during the time that we work together, we will meet weekly for approximately 50 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. For this reason I understand that if our paths cross in social situations Lissa will not initiate any greeting until I do so to protect my confidentiality.

______ I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with Lissa Carter's services as a therapist, I have a right to let her know. If I do not feel that she has resolved my complaint, I may file a formal complaint by contacting the North Carolina Board of Licensed Clinical Mental Health Counselors at (844) 622-3572 or by filing a complaint form at www.NCBLCMHC.org.

______ Should I believe that a referral is needed, Lissa will provide some alternatives including programs and/or people who may be able to assist me.

______ I understand that our agreed-upon rate for individual counseling sessions is $125 for a 50-minute session, $165 for a 50-minute couples session or $250 for an 80-minute couples session, and $190 for a 90-minute dreamwork, EMDR, or Expressive Arts session.

______ I understand that all fees for counseling are due after each session.

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______ I understand that I am responsible to pay the full charge for any appointments that are not canceled at least 24 hours prior to my appointment time, with the exception of an emergency. I understand that this fee is not covered by insurance.

______ I understand that if I do not show up for an appointment it will result in my being charged for the full missed session. I understand that this no-show fee is not covered by insurance.

______ I understand that my records and all of our communications become part of the clinical record. Adult client records are disposed of seven (7) years after the client has stopped receiving services.

______ I understand that while most of our communication is confidential there are circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- I am a danger to myself or someone else.
- I disclose child or elder abuse.
- I disclose sexual contact with another mental health professional.
- Lissa Carter LCMHCS LCAS is ordered by court order and subpoena to disclose information.
- I direct Lissa Carter LCMHCS LCAS, in writing, to release my records.

STATEMENT OF UNDERSTANDING

I have read the above, and I understand the nature of the counseling service provided and the limits of confidentiality outlined above. I solemnly swear that all of the above information is true to the best of my knowledge.

____

Client Signature   Date

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AGREEMENT FOR THERAPY

I, ______________________________________, agree to receive therapeutic services provided by Lissa Carter, LCMHCS, LCAS.

☐ I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.

☐ I understand that I am expected to be an active participant in this process.

☐ I acknowledge that I have received and understand the Notice of Privacy Practices for this office.

☐ My signature below means that I understand and agree with all of the points above.

____

Client Signature Date

PROVIDER'S STATEMENT

☐ I have inquired to insure that the patient understood the above description of the limits of confidentiality.

____

Provider's Signature Date

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HIPAA Notice of Privacy Practices

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. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment:
We may use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information may be used, as needed, to obtain payment for your health care services. For example, should you choose to utilize HSA funds to pay for counseling services, your relevant protected health information may be disclosed to the health plan to obtain approval for admission.

Healthcare Operations:
We may use or disclose, as needed, your protected information to support the business activities of your therapist's practice. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. *We may use or disclose your protected health information in the following situations without your authorization:* abuse or neglect, legal proceedings, law enforcement, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices
I acknowledge that I have received and understood the HIPAA Notice of Privacy Practices for this office:

____ __________________________
Client signature (parent or guardian if minor patient) Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Lissa Carter, LCMHCS, LCAS to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations.

____ _________________________
Client signature (parent or guardian if minor patient) Date

You have the right to request restrictions of uses and disclosures of your health information. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent.

Inner Light Counseling Collective
191 East Chestnut Street, Asheville, NC 28801
innerlightasheville@gmail.com

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