Amanda K. Crowder, LCSW, PLLC
3717 Latrobe Dr., Suite 740, Charlotte, NC 28211
704-291-1290
amandak.lcsw@gmail.com
"The start of something new brings the hope of something great." – Author Unknown

Intake Paperwork

Full Name: _____ Date of birth: _____

Home Address: _____

Preferred Phone #: _____ Ok to leave voicemail: YES/NO

Other Phone #: _____ Ok to leave voicemail: YES/NO

Email Address: _____

Religious Affiliation: _____ National Origin/Ethnicity _____

Insurance Provider: _____ Provider Phone #: _____

Policy Holder Name: _____

Member ID #: _____ Group # _____

Emergency Contact Name: _____

Emergency Contact Address: _____

Emergency Contact Phone #: _____

Emergency Contact's Relationship to You: _____

How did you hear about me? _____

Primary Reason(s) for Seeking Therapy:

_____
_____
_____
_____

From whom or where do you receive your medical care?

Clinic/Doctor's name: _____ Phone #: _____

Current Medications: _____

Professional Disclosure Statement

Thank you for choosing Amanda K. Crowder, LCSW, PLLC for your therapeutic needs. Starting something new can be difficult and scary. If you have any questions, please do not hesitate to ask me at any time. This document is to inform you of my policies, state and federal laws, and your rights.

Professional Credentials

I earned a Master's degree in Social Work from the University of North Carolina at Charlotte in 2012. I am a licensed clinical social worker (#C009110) through the North Carolina Social Work Board. My clinical experience is with treating children, adolescents, adults, and families through different stages of their life.

Informed Consent & Counseling Agreement

Counseling Relationship

This is a voluntary process. My goal as your therapist is to work collaboratively with you to achieve the goals that brought you into my office. This is a professional relationship, rather than a social one. Please do not offer me gifts or ask me to engage in social activities with you (this includes social networking). Based upon the information that you provide to me and the specifics of your situation, I will make recommendations to you regarding your treatment. If at any time you are unhappy with the services received, it will be your responsibility to make that known so that we can discuss the matter further. If for any reason you decide my style of therapy is unhelpful, I will assist you in finding a more suitable therapist.

During your time in treatment, we may explore intense and emotional issues that may be distressing or lead to discomfort. In addition, some of the work done during your therapy sessions may seem unrelated to the original reason you came to therapy. Although, I expect you to benefit from therapy, I cannot guarantee specific results. Therapy is a personal exploration and may lead to major changes in your life. These changes may affect significant relationships, your job, and/or your understanding of yourself. However, the therapy process is to be seen as helpful, and as your therapist I plan to work with you to achieve the best possible results.

Length & Frequency of Sessions

Sessions are typically 45-55 minutes in length weekly, bi-weekly, or monthly depending on your needs. The appointment date and time will be a mutual agreement between myself and you, as the client. Your consistent attendance for sessions greatly contributes to a successful therapy outcome.

Record Keeping
Initial paperwork from today, my notes, billing records, and any work shared and completed during therapy will become a part of your record.

Counseling Fees
I am contracted through Blue Cross Blue Shield, United Healthcare, Tricare, Cigna, and several EAP affiliated insurance companies. If self-pay, the cost of services is $80 per 45 minute session or $100 per 55 minute session. Phone consultations may be billed as a session if the call exceeds 30 minutes. Phone consultations are not covered by insurance benefits. Written reports requested by clients and correspondence with other professionals will be completed at a rate of $100 per hour. The cost of services may be re-assessed annually. Payment is expected at the end of each session via cash or credit card (no personal checks will be accepted). A receipt will be provided, upon request, including all information necessary for insurance carriers and health savings accounts.

I do not provide appointment reminders. If you arrive late for a session, you will still be charged for the entire amount. If you anticipate being late, please contact me within 15 minutes of your appointment time. If you are more than 20 minutes late, I will count this as a missed appointment and you will be responsible for the missed session fee. If you are unable to attend a scheduled session and need to cancel or reschedule, you are expected to notify me at least **24 hours in advance**. If you do not provide me with at least a 24 hour notice, you will be responsible for a **$50.00 missed session fee**. Please note that insurance companies **will not** cover charges for missed appointments.

Confidentiality & Limits of Confidentiality
Treatment is confidential. This means the client's name and any information about the client will not be discussed without the client and/or guardian's written permission. The confidentiality of information you share with me is protected by law and by my professional ethics. However, there are several exceptions to this policy: **By law, all suspected child abuse and/or neglect must be reported; action must be taken if it is determined a client is in danger to themselves or to someone else; and it is possible that client information/records will be released if ordered by a court**. Please read over the Privacy Practices for specifics about what information may be disclosed for insurance and billing purposes. In keeping with generally accepted standards of practice and to ensure quality care, I occasionally consult with other mental health professionals.

Emergencies

I **will not** be available at all times, therefore if you are experiencing a mental health emergency that you feel requires immediate support and I am not available, please contact the Behavioral Health Charlotte Emergency Room at 704-444-2400. In the event of a life threatening emergency, please call 911.

Methods of Contact

Phone contact: You may reach me by calling 704-291-1290. Sometimes, I will not be able to answer your call. I will make every effort to return you call within 24 business hours.

Email contact: Please feel free to email me at amandak.lcsw@gmail.com. Please be aware that emails sent to this address are not encrypted. Since this is not a confidential method of communication, please limit email communication to appointment requests and/or cancellations. Email **will not** be used as a substitution for seeing me. Email should not be used to communicate sensitive medical information such as diagnoses, testing results, and/or substance abuse information. Emails sent will become a part of your medical record.

Grievances

If, at any time, you are dissatisfied with any aspect of my work, please speak to me about your concern. If you think you have been treated unfairly or unethically, and we cannot resolve the problem, you may contact the North Carolina Social Work Licensure Board, for clarification of client rights and/or to lodge a formal complaint.

North Carolina Social Work Board
P.O. Box 1043
Asheboro, NC 27204
1-800-550-7009

NC Disability Rights
3724 National Dr., Suite 100
Raleigh, NC 27612
919-856-2244

Please sign below indicating you have read and understand the counseling agreement. A copy will be returned to you and I will retain a copy for my confidential files.

Client Name: _____ Signature: _____ Date: _____

Client Name: _____ Signature: _____ Date: _____

Legal Guardian: _____ Signature: _____ Date: _____

Legal Guardian: _____ Signature: _____ Date: _____

Therapist: Amanda Crowder, LCSW Signature: _____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

I understand your health record contains personal information about you and your health. I am committed to protecting your healthcare information. I have a duty to maintain the privacy of your health information and to provide you with this notice.

How I can use and disclose your protected health information (PHI):

For Treatment: This practitioner may use and share PHI with others to provide and coordinate your healthcare treatment. This includes consultation with clinical supervisors and/or other treatment team members for diagnosis, treatment planning, treatment, and continuity of care.

For Payment: This practitioner may use and share PHI with others (health plans, insurance companies) to bill and collect payment for services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or understanding utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Healthcare Operations: This practitioner may use and disclose PHI with others in order to make improvements to services in business-related matters, such as audits and licensing purposes.

Required by Law: Under the law, we must disclose your PHI to you upon your request. It is the policy of this practice to not release any information about a client without a signed release of information, except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: This practitioner may use or disclose PHI without your consent or authorization in the following circumstances.

- Abuse and/or Neglect: If this practitioner has reason to suspect that a child or vulnerable adult is being abused or neglected, this practitioner is required by law to report the matter immediately to the North Carolina Department of Social Services. This includes the admittance of prenatal explore to controlled substances.
- Duty to Warn: If this practitioner is engaged in her professional duties and you communicate to her a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and this provider believes you have the intent and ability to carry out that threat immediately or imminently, this provider must take steps to protect third parties. These precautions may include warning the potential victim(s), or the parent and/or guardian of the potential victim(s), if under 19 or notifying a law enforcement officer.

- Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for the information about your diagnosis and treatment and the records thereof, such information is privilege under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However if you move to "block" the subpoena, this provider is required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released.
- Deceased Patients: This practitioner may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for your care prior to death, based on your prior consent.
- Other: This practitioner may release your PHI when complying with worker's compensation laws, law enforcement purposes, and if there is a serious threat to public safety. In addition, professional misconduct by a healthcare professional must be reported by other healthcare professionals.
- Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. However, therapy is most effective when there is a "good faith" agreement between the minor and parent/guardian, so that the child can be assured of his/her confidentiality while in sessions. This practitioner will discuss the treatment progress of a minor client with the parent/guardian. This practitioner also encourages parents/guardians to be actively involved in their child's treatment.

<u>Patient's Rights</u>

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your PHI. However, this practitioner is NOT required to agree to a restriction request.
- Right to Receive Confidential Communications by Alternative Means & at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- Right to Inspect & Copy: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. *This practitioner charges $2.00 per page for copies*. You may request that a copy of your PHI be provided to another person.
- Right to Amend: If you feel that the PHI this practitioner has about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy.
- Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your written request, this practitioner will discuss with you the details of the accounting process.

Complaints

If you believe I have violated your privacy rights, or you disagree with a decision made about the access to your records, a direct conversation is welcomed and assurances are made that no retaliation will be mad. You may also send a written complaint to the secretary of the U.S. Department of Health and Human Services. You may also make a complaint to the North Carolina Social Work Board.

North Carolina Social Work Board
P.O. Box 1043
Asheboro, NC 27204
1-800-550-7009

Notice of Understanding

My signature below indicates that I have reviewed and understand the above document and I am acknowledging that I have a copy for my records.

_____ _____
Signature of client or parent/guardian Date

_____
Printed name of client of parent/guardian

Court and Legal Fees

Clients are discouraged from having me subpoenaed or having me provide records for the purpose of litigation. Even though you are responsible for the testimony fee, it does not mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion. Furthermore, if I see both a child and parent separately, there is an obvious conflict of interest. I would rather not damage the trust I have built in the counseling relationship with each client, especially if I am still seeing that person for therapy.

If I am to receive a subpoena, the attorney or office staff will need to call my office and set up a time for the subpoena to be served during my specified office hours. I request a minimum of 72 hours notice of any court appearance so that schedule changes for my clients can be made within a reasonable time frame. Please note: If a subpoena or notice to meet attorney(s) is received without a minimum of 72 hours notice there will be an additional $200 express charge, which must be paid prior to my appearance in the courtroom.

When it comes to court action, the following fees are in effect:

1. Preparation Time (including submission of records): $100/hour (billable in 15 minute increments)
2. Phone calls: $100/hour (billable in 15 minute increments)
3. Depositions/Mediations/Arbitrations: $200/hour
4. Time required in Giving Testimony: $200/hour
5. Mileage: .40/mile
6. All attorney fees and costs that are incurred by me as a result of the legal action.
7. Filing documents with the court: $60 flat fee
8. A minimum charge for a court appearance: $750

A retainer of $750 is due at least 72 business hours before the scheduled court appearance. The reminder of the costs will be billed after the court appearance and will be due upon receipt. If I am subpoenaed in the case is continued with less than 48 business hours notice prior to the beginning of the day of the scheduled court appearance and/or the testimony is not given then the client will be charged $375 (in addition to the original retainer of $750 for having to appear in court). All fees listed above are doubled if the therapist is scheduled to be going out of town. Bills are presented to clients on a weekly basis and payment is expected upon receipt.

I understand the above fee schedule and agree to these terms.

_____

Client (or Legal Guardian of Client)

Release of Information

Client Name:_____ Date of Birth: _____

I hereby authorize Amanda K. Crowder, LCSW, PLLC to disclose specific health information:

Release Information From:	Release Information To:
Amanda K. Crowder, LCSW, PLLC	
3717 Latrobe Dr., Suite 740	
Charlotte, NC 28211	
Phone: 704-291-1290	

Purpose of Release: Ongoing Communication/ Legal Purposes/ Continued Patient Care

This release allows permission to provide and permission to receive information from identified agencies.

Dates of release: From: _____ To: _____

Information to be released: Entire Record (not including psychotherapy notes)/ Assessment/ Attendance dates/ Other, please specify: _____

Patient's Rights

I understand that I can cancel this authorization at any time. I must cancel in writing and send or deliver cancellation to the releasing party or practice named above. Any cancellation will apply only to information not yet released by either party.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, this recipient my not re-disclose this information without my further written authorization unless otherwise provided for by state or federal law.

I understand this is a full release including information related to behavioral/ mental health, drug or alcohol treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.

Amanda K. Crowder, LCSW, PLLC will not share or use my health information without my permission other than the ways listed in the Notice of Privacy Practices.

Refusing to sign this form will not prevent my ability to get treatment. I may request a copy of this signed authorization.

Signature of Client: _____ Date: _____

Print: _____

Signature of Parent/Guardian: _____

Print: _____ Date: _____

Signature of Witness: _____ Date: _____

Print: _____