Calming Waters Counseling Services
447 S. Sharon Amity Rd, Suite 105, Charlotte NC 28211
P: 980-299-7436
F: 980-226-5507
www.amandaklcsw.com

Date: ________________

Intake Paperwork

Client Full Name: ____
Preferred Name: ______________________________
Marital Status: Single / Married / Separated / Divorced / Widow(er)
Date of birth: __________________
Street Address: ____
City / State / Zip Code: ____

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

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

Email Address: ____

Parent Full Name: ____

____

Religious Affiliation: ______________ National Origin/Ethnicity ______________________

Insurance Provider: _______________________ Provider Phone #: ___________________

Policy Holder Name: ____

Member ID #: ___________________________ Group # ___________________________

Place of Employment: ____

Emergency Contact Name: ____

Emergency Contact Address: ____

Emergency Contact Phone #: ____

Emergency Contact's Relationship to You: ____

How did you hear about us? ____

Primary Reason(s) for Seeking Therapy: ____

From whom or where do you receive your medical and/or psychiatric care?

Clinic/Doctor's name: ______________________________ Phone #: _________________

Current Medications: ____

Welcome and thank you for choosing Calming Waters Counseling (formally known as 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 at any time. This document is to inform you of the company's policies, state and federal laws, and your rights.

Informed Consent & Counseling Agreement

Counseling Relationship

This is a voluntary process. The goal of each therapist is to work collaboratively with you to achieve the goals that brought you into the office. This is a professional relationship, rather than a social one. Please do not offer gifts or ask to engage in social activities (this includes *social networking*). Based upon the information that you provide and the specifics of your situation, recommendations will be made 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 it can be discussed. If for any reason you decide our services are unhelpful, referrals can be provided for a more suitable therapist.

During your time in treatment, you 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, the expectation is that you benefit from therapy, no specific results can be guaranteed. 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 our plan is 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 the therapist and you, as the client. Your consistent attendance for sessions greatly contributes to a successful therapy outcome.

Record Keeping

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

Counseling Fees

Calming Waters Counseling Services is in network with various insurance providers. Please be mindful, that it is *your responsibility* to verify benefits. If self-pay, the cost of services is $120 per session. Phone consultations may be billed as a session if the call exceeds 10 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). This also applies to invoices/bills sent; payment is expected upon receipt. In special circumstances, such as parents paying separately, payment is due the Sunday prior to the next scheduled appointment. If payment is not received, then this appointment will be cancelled. A receipt will be provided, upon request, including all information necessary for insurance carriers, health savings accounts, and flex spending accounts.

Appointment reminders are not provided. If you arrive late for a session, you will still be charged for the entire amount. If you anticipate being late, please contact your therapist within 15 minutes of your appointment time. If you are more than 15 minutes late, this will count 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 provide notification at least **24 hours in advance**. If you do not provide at least a 24-hour notice, you will be responsible for a **$75.00 missed session fee**. Please note that insurance companies **will not** cover charges for missed appointments. If you miss more than 2 appointments consecutively, we will assume that you are no longer interested in services and will provide you with a referral for any further needs.

Credit Card on File

For ease of payment for services, please complete the attached form which will authorize me to charge your credit card for fees associated with scheduled appointments, missed appointments, phone consultations (in excess of 10 minutes), or written reports or consultations requested.

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 this company is protected by law and by 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, this practice occasionally consults with other mental health professionals.

Emergencies

Someone **will not** be available at all times, therefore if you are experiencing a mental health emergency that you feel requires immediate support and your assigned therapist is 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 call this office directly at **980-299-7436**. Sometimes, you will not be able to get in contact with the office, or your assigned therapist. Leave a message and someone will try to return your call within 48 business hours.
Email contact: Please feel free to use email. We ask that you please limit email communication to appointment requests and/or cancellations. Email **will not** be used as a substitution for seeing your assigned therapist. 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 the work performed at this company, please speak to your assigned therapist 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 a copy will be retained for your confidential file.

Client Name: ____________________ Signature: ____________________ Date: ______

Client Name: ____________________ Signature: ____________________ Date: ______

Legal Guardian: __________________ Signature: ____________________ Date: ______

Legal Guardian: __________________ Signature: ____________________ Date: ______

Therapist: ______________________ 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.

This practice understands your health record contains personal information about you and your health. This practice is committed to protecting your healthcare information. This practice has a duty to maintain the privacy of your health information and to provide you with this notice.

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

For Treatment: This practice 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 practice 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 practice 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 practice may use or disclose PHI without your consent or authorization in the following circumstances.

- Abuse and/or Neglect: If this practice has reason to suspect that a child or vulnerable adult is being abused or neglected, this practice 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 practice 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 practice 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 practice 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 practice will discuss the treatment progress of a minor client with the parent/guardian. This practice also encourages parents/guardians to be actively involved in their child's treatment.

Patient's Rights

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your PHI. However, this practice 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 practice 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 practice 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 practice will discuss with you the details of the accounting process.

Complaints

If you believe this company has 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 made. 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 any one provider in this practice subpoenaed or provide records for the purpose of litigation. Even though you are responsible for the testimony fee, it does not mean that the testimony will be solely in your favor. We can only testify to the facts of the case and to the specific therapist's professional opinion. The goal is not to damage the trust that has been built in the counseling relationship with each client, especially if the client continues in therapy.

If a subpoena is to be received, the attorney or office staff will need to call my office and set up a time for the subpoena to be served during the specified office hours. We request a minimum of 72-hour notice of any court appearance so that schedule changes for 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-hour 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: $0.40/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 1 week 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 and the case is continued with less than 48 business hour 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 practicing as Calming Waters Counseling Services to disclose specific health information:

Release Information From:	Release Information To:
Amanda K. Crowder, LCSW, PLLC practicing as Calming Waters Counseling Services	
447 S. Sharon Amity Rd, Suite 105	
Charlotte, NC 28211	
P: 980-299-7436 F: 980-226-5507	

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 may 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 practicing as Calming Waters Counseling, 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: ________________________ Date: _________________

Print: ____

Signature of Witness: ______________________________ Date: _________________

Print: ____

Revised 10/17/2018

Credit Card Authorization

Credit Card Type (Circle)	VISA	MASTERCARD	AMERICAN EXPRESS	DISCOVER
CARDHOLDER'S NAME (As it appears on card)				
CARD NUMBER (XXXX-XXXX-XXXX-XXXX)				
EXPIRATION DATE (MM/YY)				
CARD CVV (XXX) (Security Code)				
Billing Zip Code				

By signing this form, you authorize this practice to charge your credit card for fees associated with scheduled appointments, missed appointments, phone consultations (in excess of 10 minutes), and written reports or consultations requested.

In addition, card holder is responsible for notifying this practice of any changes to subject credit card, e.g. change in expiration date, new CVV, or cancellation of card. These changes must be provided in writing.

______________________________ ____________________

Signature of Card Holder Date

____

Printed name of Card Holder

Revised 10/17/2018