Denouement Counseling
336.365.6626

Mary Roberts, MA, LPC

1107 W Market St
Greensboro, NC 27403

CHILD CLIENT INTAKE FORM

Please fill out this form before your first session. The information will help me assist you more effectively and efficiently.

Parent/Guardian Full Name____

Address____City________________

State_________Zip___________Email____

Phone: Home______________________Cell_____________________Work____________________

Preferred Method of Contact ____

Second Parent's Name ____

Marital status of parents? Single Married Separated Divorced Widowed

-Do both parents maintain PHYSICAL custody of child? ______________

-If no, do both parents maintain LEGAL custody of child? ____________

-If no, please explain and/or provide Denouement Counseling with official documents outlining custodial arrangements.

____

Stepparent's Name (if applicable): ____

Minor Client's Name____

DOB__________________Age_________ Gender _____ Male _____ Female

Address (if different from above) ____

City____State____________Zip______________

School Name____Grade_______________

Child's Physician_______________________________________Phone____________________

Physician's Address ____

Past injuries or major illnesses ____

Please list all medications your child is currently taking ________________________

____

____

Would you like to sign a release of information for me to talk with your prescriber? ____________

Has the child or any family members ever been diagnosed with a mental illness? Yes______No______

Has the child or any family members ever attempted to take their own life? Yes______ No ______

Has the child or any family members received previous counseling or psychotherapy?

Outpatient? Yes / No Providers and dates: ____________________________________

Inpatient? Yes / No Providers and dates: ____________________________________

What would you and your child like to gain from counseling? ______________________

____

What are the most significant stresses that the child is currently dealing with ______________________________

____

Does the child have any history of abuse?________sexual?________physical?________verbal/emotional/mental?

Circle any of the following issues that are a current concern for the child or adolescent:

Anger	Depression	Loss of Job/Work	Substance Abuse
Self Esteem	Relationship with Children	Conflict in Work Relationships	Grief
Identify	Loss of Hope, Meaning, or purpose	Suicidal Feelings	Anxiety
Sexual Problems	Religious Doubts	Guilt/Shame	Loneliness
Relationships with Significate other	Abuse	Stress	Trauma

Other ____

Is there anything else you would like me to know about the child or adolescent?

____

____

____

____

PROFESSIONAL DISCLOSURE STATEMENT

Mary Roberts, MA, LPC
Master of Arts in Counseling Psychology (SST&P, 2012)
Licensed Professional Counselor, North Carolina (12103)
1107 W Market St, Greensboro, NC 27403 • 336-365-6626
mary@denouementcounseling.com

The purpose of this document is to make you, the client, aware of who I am as a counselor and logistics of what you can expect from our time together. When you sign this document, you are agreeing to the terms and consenting for treatment with me. After reading this document, if you have questions about what you read, please let me know and I will be happy to provide you with answers. I am excited for the opportunity to serve you and hope that our time together will bring you a further sense of self-awareness.

My Qualifications and Counseling Background

My highest level of education is an MA in Counseling Psychology from The Seattle School of Theology & Psychology in June of 2012. I am a Licensed Professional Counselor in North Carolina (12103).

My education and training is in individual, group, couples, and family counseling with all ages in the areas of behavioral-emotional, cognitive, anxiety, and depressive disorders, along with psychosis, trauma and abuse, as well as personality disorders. My education and training has provided me with a diverse theoretical background, which includes psychodynamic psychotherapy, cognitive behavioral therapy, dialectical behavioral therapy, psycho-educational, object relations, and interpersonal/relational therapy. My year-long internship experience was primary focused on evidence-based practices in the area of client-centered therapy. My school also provided me with a year and a half practicum experience with two licensed counselors and a small group of my fellow students. I have completed Phase I, II, and III Brainspotting training and use this modality frequently. I currently see individuals for all of the areas listed above.

Acceptance and Closure

I recognize that every client is different and I feel comfortable tailoring my theoretical approach to meet the needs of each individual client. If, for any reason, I feel as though I do not have the proper training to meet the needs of any client, I will provide at least three references of other professionals who have training to work effectively with the client. If you decide to leave counseling at any point in time, for any reason, I will respect your decision. I do invite you to have a conversation with me about any changes you would like to make in your treatment.

Length of Services
All therapy sessions are fifty (50) minutes unless otherwise agreed upon at the beginning of treatment. To be considerate of your time, my time, and the time of my other clients, please arrive to your sessions on time. I will do the best to end client's sessions on time so that your session can begin on time.

Fees and Payment
My standard fee for a 50 minute session is $115 and **payment is taken at the beginning of each session**. I currently accept cash, check, debit, or credit card as forms of payment. Please make checks payable to **Denouement Counseling**. If you have coverage through Blue Cross Blue Shield, your fee will depend on your copay, coinsurance, and deductible. Please let me know on intake that you wish to use your BCBS coverage and we will find out what your session fee is in the first appointment but no later than the second appointment.

Text Message Reminders
By initialing the blank space, __________ I agree to receive text message reminders of my appointments.

By initialing the blank space, __________ I decline to receive text message reminders of my appointments.

Cancellations/No Shows
If I need to cancel your appointment for any reason, I will attempt to notify you at least 24 hours in advance. If I cancel your appointment at any time, you are not responsible for any fee. If you need to cancel an appointment for any reason, please do so at least 24 hours in advance otherwise you will be responsible the fee of the missed session. If you have coverage through Blue Cross Blue Shield, and you cancel under 24 hours before your appointment time, you are responsible for the full cost of your appointment including what BCBS would have covered which is currently around $100. I allow **one** late cancel/no show to go without a fee per client. This means that your first late cancel/no show does not incur a fee, however, **any late cancel/no show for any reason without 24 hour notice** after the first allowance, will carry the full fee of the session. If you arrive late, we can finish the remainder of the 50 minutes session; you are still responsible for the full fee of the session. If you need to leave the session early, you are still responsible for the full fee of your visit.

Health Insurance and Receipts for Services
Your health insurance may cover your sessions with me as an out of system provider, however I currently only an in-network provider with Blue Cross Blue Shield of North Carolina. I file all of my client's BCBS claims with BCBS directly and when you sign this document you agree to allow me to file your claims.

You also agree to not file your claims yourself unless you have some other coverage other than BCBS. As a client, you are responsible for checking with your insurance company about coverage and for filling out claim forms. I am happy to provide receipts for sessions upon request.

Use of Diagnosis

Most insurance companies require a diagnosis in order to reimburse a client for services received. Insurance companies also do not cover all diagnoses however, if yours is one that is covered I will provide you with your diagnosis before any forms are submitted to the insurance company. Your diagnosis will become a permanent part of your insurance record. Typically insurance companies will want a receipt, which will include your name, your diagnosis, the date of service, the type of service you received (group, individual, family therapy, etc.), as well as my name and qualifications. This does mean that confidentiality will not be at the same level as if you only paid out of pocket.

Contacting Me

Please feel free to contact me at my phone number, 336-365-6626 or by email at **mary@deneoumentcounseling.com**. For various reasons, I cannot guarantee that I will be available by phone at all times. If you are not experiencing an emergency, please leave me a message and I will return your call as soon as I possibly can, however it may take me up to two days to return your call. If I am going to be on vacation or away from the practice for any extended period of time, I will inform you of those dates in advance and will give you references for other licensed professionals who are willing to provide help if needed.

I do not handle emergencies by phone or email. **If you believe that you are having a mental health emergency or are unable to keep yourself safe**, either go to your local hospital emergency room or call 911 and ask to speak to a mental health worker on call. If you are admitted to a hospital, please leave me a message to let me know that you are safe. We can work out the details of you returning for services after you are physically safe.

No Shows/Late Cancel and Failing to Reschedule

If you fail to come to an appointment or late cancel and do not contact me to reschedule within 3 weeks of the missed appointment, I will take this as proof that you wish to discontinue your treatment with me. I will discharge your file three weeks after the missed appointment and by signing this document you are acknowledging that failure to reschedule is proof of termination of treatment with me. You are welcome to continue treatment at any time and are free to contact me via phone or email in order to get back on my schedule after I discharge your file.

Confidentiality

All of my services will be rendered with respect and empathy for the client as well as in full compliance with all ethical standards and norms. I abide by the ACA Code of Ethics, which can be found at http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx.

My record of our sessions and communication is available to you at any time upon written request. I abide by all of the HIPPA regulations, however, I will only disclose your records to family or other professionals if you have given me express written and signed consent.

As your therapist there are four circumstances in which confidentiality cannot be maintained: First, when I have reason to believe that you intend to harm another person or yourself; Second, when I have reason to believe that a child, a person with a disability, or an elderly person has been or is being abused or neglected; Third, if I am ordered by state court of law to release information about your clinical record with me; Finally, in consultation for supervision with other clinicians during which names will not be used.

Complaints
If you have any concerns or complaints at any point in our time together, I am always willing to discuss changes that need to be made however if you feel as though I have violated your rights as a client you may file a complaint against me. If the complaint is for a mental health diagnosis only please submit the complaint to the North Carolina Board of Licensed Professional Counselors using the information below.

North Carolina Board of Licensed Professional Counselors
PO Box 77819, Greensboro, NC 27417
Phone: 844-622-3575 or 336-217-6007 | Fax: 336-217-9450
E-mail: complaints@ncblpc.org
Complaint form at: http://www.ncblpc.org/forms/10_Complaint_Form/Complaint_Form.pdf

Acceptance of Terms
If you have any questions about the information contained in this document, please discuss them with me. Please sign and date below to indicate that you have read, understand and agree to the terms presented to you in this form. This document will be kept in your confidential records.

By signing this document, you are agreeing that you read and understood this professional disclosure statement and consent for treatment statements.

Client sign: ______________________________ Date: ________

Client Printed Name: ______________________________ Date: ________

Legal Guardian Sign: ______________________________ Date: ________

Legal Guardian Print: ______________________________ Date: ________

Counselor: ______________________________ Date: ________

NOTICE OF PRIVACY PRACTICES – HIPPA

Please read this notice carefully because it is about your privacy regarding your healthcare information. I take your privacy seriously and am required by the laws of the United States and the state of North Carolina to keep your health information private. This notice is about how your healthcare information may be used and/or disclosed and how you can obtain a copy of your healthcare information. I am required by the laws of the United States and the state of North Carolina to give you notice of my privacy practices and to abide by them.

This notice takes effect on June 1, 2017 and will be effective until I replace it. I am legally allowed to change these practices as long as they are in accordance with what is permitted and required by law. If I change these practices at any time, I will amend this notice and give copies to all active clients.

Please ask any questions you have after reading this notice. I will make a copy of this notice for you at no charge for your personal records.

Your Rights Regarding Your Healthcare Information

1. You have to right a copy of this notice.
2. With limited exception, you have a right to access your healthcare information that I use and maintain for my records. If you would like a copy of your healthcare information, please submit a written request and I will provide you with one copy of your healthcare information free of charge. Any additional copies will require a fee of $.25 a page.
3. Upon inspection of your healthcare information, if you feel as though your information is incorrect or incomplete, you have the right to request me to amend your information, however, I am not required to agree to the amendment.
4. You have a right to request a limitation or restriction on how I use or disclose your healthcare information for treatment, payment, or other health care operations. I am not required to agree with the request.
5. You have a right to request a written accounting of all occasions that I have disclosed or used your healthcare information for other than payment, treatment, or other operations. I will provide you with one copy of this accounting free of charge every 12 months. If you request this accounting more than once in a 12 month period, I will charge you a reasonable fee based on the cost of me tabulating these disclosures.
6. You have a right to requested that I communicated with you about your healthcare information in a certain way or at a certain location.

Situations When Your Healthcare Information May be Shared

1. To consult with your other healthcare professionals like physicians or psychiatrists. I will only do this with written authorization from you.
2. To anyone you give written authorization to have your healthcare information. You have the right to revoke this authorization at any time however, it will only effect your

healthcare information from that point on.

3. To any person who is required by federal, state or local law to have lawful access to your healthcare information.
4. To a third party payer in order to receive payment for services I provide for you. This may include your insurance company that I may be an out of system provider for. All claims need to be filed by the client individually; if you need a receipt for services I provided for you, please ask.
5. For my business practices which include but are not limited to the following: my supervising staff, to improve the quality of my services, in connection with licensing, credentialing, or certification activities or to evaluated the effectiveness of my services.
6. To a legal guardian, family member, person responsible for your care or a person designated as your personal representative in the event of an emergency. It is my responsibility to give you a chance to object to a disclosure of this kinds. If you object, are not present, or are incapable of responding, I may use my professional judgment to disclose your healthcare information in your best interest during an emergency. It is still my responsibility to protect your healthcare information, so I will only use or disclose the parts of your healthcare information that are necessary or crucial at the time of the emergency.

When Your Healthcare Information can be Disclosed Without Your Authorization

There are four circumstances in which I cannot guarantee confidentiality, legally and/or ethically:

1. When I believe that you plan and intend to harm yourself or another person.
2. When I believe that a child or elderly person has been or is in danger of being neglected or abused.
3. When ordered by a judge to release information about your healthcare information about your time with me.
4. Confidentiality is waved if I or any counselor is or becomes a party defendant to a criminal, civil or disciplinary action arising from a complaint filed by the client.

Your healthcare information which I retain for my records will be held for a minimum of seven years after your last session with me. When that 7 years has elapsed, your record will be destroyed in a way that protects your privacy such as shredding or burning.

None of your healthcare information will be used by me for marketing, development, or any other related activities without your written authorization. Without your written permission, I cannot use, share, or disclose your healthcare information in any ways other than those explained in this notice.

If at any point in time, you think your privacy and confidentiality rights have been violated by me, or you would like to file a complaint about my privacy practices, you may write to the North Carolina Board of Licensed Professional Counselors – PO Box 1369 Garner, NC 27529; Phone: 919-661-0820; Fax 919-779-5642

Consent to This Privacy Policy

Please print, sign and date below, acknowledging this form and consenting to this form as a condition of receiving mental health services from Mary Roberts, MA, LPC, with Denouement Counseling.

I was given a copy of this notice and an opportunity to ask questions I had. I understand the terms of this notice and consent to them. I have the freedom to ask any questions I have at any time.

Client Signature ____ Date ____________

Client's Printed Name____ Date ____________