PROFESSIONAL COUNSELING ASSOCIATES 251-626-5797

PATIENT NAME (Last First Middle)			Have you been treated at our facility in the last 3 years? ☐ Yes ☐ No
DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	MARITAL STATUS ☐ Single ☐ Married ☐ Other

MAILING ADDRESS	APT/SUITE#	CITY	STATE	ZIP
STREET ADDRESS (IF DIFFERENT)	APT/SUITE#	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	MOBILE PHONE

PHONE NUMBERS WHERE WE MAY LEAVE MESSAGES ABOUT YOUR HEALTHCARE? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone	EMAIL ADDRESS	
EMPLOYER	PRIMARY CARE PHYSICIAN	PHONE NUMBER

RESPONSIBLE / BILLING PARTY INFORMATION

NAME (Last First)	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other:

ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	HOME PHONE	WORK PHONE	MOBILE PHONE

INSURANCE INFORMATION (GUARANTOR)

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
POLICY HOLDER NAME		**POLICY HOLDER NAME**	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other:		RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other:	
INSURANCE CARRIER		INSURANCE CARRIER	
POLICY #	GROUP #	POLICY #	GROUP #
EMPLOYE		EMPLOYER	

ADDITIONAL INFORMATION

EMERGENCY CONTACT		Relationship
HOME PHONE	Cell Phone	

PROFESSIONAL LICENSING BOARD:	CONTACT:	PHONE NUMBER:

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PROFESSIONAL COUNSELING ASSOCIATES

NAME: _______________________________________ DATE: ____

DATE OF BIRTH: _________________________ DRUG ALLERGIES: ______________________________

What do you hope to achieve through counseling? ____
____
____

List any medications you are taking:

Name of Medication	Prescribing Physician	Purpose of this medication

List any serious illness, injury or surgery you have had:

Illness, injury or surgery	Date

Please check any problems you have been experiencing:

_____Fear
____ Loss
_____Anxiety/Nervousness
_____Depression
_____Loss of control (crying, anger, etc.)
_____Physical harm _____Self
_____Others
_____Suicidal thoughts
_____Financial problems
_____Divorce
_____Insomnia

_____Alcohol/Drug use
____Appetite change
_____Weight gain/loss
_____Sexual
______Memory problems
_____Impulsivity
_____Loneliness
_____Health problems
_____Legal problems
_____Problems with children
_____Sensations (sounds, sights, others) that other people don't experience

_____Headaches
_____Thinking problems
_____Problems concentrating
_____Feelings of separation
_____Energy/Fatigue
_____Lack of ambition
_____Stress
_____Temper
_____Difficulty in relationship(s)

Others not listed: ____
____
____

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MEDSHEET

PROFESSIONAL COUNSELING ASSOCIATES

Ashley C. Simpson, LPC, ACRPS
Kay Bush Sorrells, LPC
Chery Holmes, LPCS, MAC, CCHI
Alana Wright, MS, LFT, LPC
Hiram Keith Johnson, LCSW
Rochelle W. Murrell, M.A., ALC
Deborah Schiller, LPC, CSAT-S, CMAT, NCC

Welcome to Professional Counseling Associates Intensives (PCA). This document contains important information about our professional services and business policies. Please read it carefully and note any questions you may have so that you and we can discuss them at our next meeting.

This consent packet constitutes a binding agreement between us.

As a client you are voluntarily agreeing to participate in psychotherapy and psycho-education. You have the right to terminate your involvement at any time without penalty. Clients are viewed as partners with the therapist in the sense that they are involved as fully as possible in each aspect of their therapy.

The process of therapy requires a commitment of high degree of willingness from each individual to open up one's personal and family life which may be difficult to address. There are no guarantees in therapy. The level of healing is in direct proportion to a client's level of willingness and desire for change. As you grow in awareness and understanding, many changes may occur, as a result of therapy, which were not expected in the beginning. Healing is not an overnight occurrence; nor is the therapeutic process. Upon completion of the intensive workshop, recommendations will be made for follow up according to the individual needs of the client.

The counselor's role in therapy is to guide the client into gaining insight and understanding and in so doing, help them to independently make healthier decisions for themselves and their families. This is provided through our out-patient Intensive Workshop and counseling for individual, marriage and family problems. Additional services are provided when deemed necessary and appropriate.

Contacting Us

During participation in the Intensive Workshop, a therapist will be available to you 24 hours a day by phone.

If you experience a life-threatening emergency, call 911 or go to the nearest hospital emergency room and request to be seen by a mental health professional.

Billing and Payments

A non-refundable down payment is due to reserve a spot in the Intensive Workshop. The remaining balance is due in full at the time service is rendered. If you become involved in litigation that requires your therapist's participation, you will be expected to pay for the professional time required, even if your clinician is compelled to testify by another party. _______ (initials)

Most insurances are accepted and will be filed as a courtesy. It is the client's responsibility to know what mental health coverage is available to them. Any information we obtain on your behalf is not a guarantee of payment. Clients will be responsible for co-pays and deductibles and any insurance payments that we were unable to collect due to insufficient information. Clients will be responsible for all charges incurred that are not covered by their insurance plan. ________ (initials)

Should it become necessary for this account to be referred to an attorney and/or third party for collection, client is responsible for all collection expenses. There is a charge of thirty-five dollars ($35.00) for all returned checks due to Non Sufficient Funds. _______ (initials)

Privacy Policy (Summary)

The therapists at PCA are ethically bound to maintain the confidentiality of our work together. The only exceptions are in specific circumstances where you have authorized the release of information to another party (i.e. a medical provider) or when reporting is mandated by law.

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In general, law protects the confidentiality of all communications between a client and a clinician, and we can only release information about you to others with your written authorization. However, there are a number of exceptions. In most judicial proceedings, you have the right to prevent the clinician from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require your clinician's testimony if he/she determines that resolution of the issues demands it.

There are some situations in which we are legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. For example, if we believe that a child, an elderly person, or a disabled person is being neglected or abused, we may be required to file a report with the appropriate state agency. If we believe that a client is threatening serious bodily harm to another person, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, we may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection. Such situations are rare. Should such a situation occur, we make every effort to discuss it fully with you when we are required by law to take action.

We may occasionally find it helpful to consult about a case with an outside professional. In such consultations, we make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, we will not tell you about these consultations unless we feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in information you about potential problems, it is important that we discuss any questions or concerns you may have at your next session. The laws governing these issues are complex, and we do not offer legal advice. While we are happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

Professional Records

Both law and the standards of our profession require that we keep appropriate treatment records. You are entitled to receive a copy of the records at your written request, unless we believe that seeing them would be emotionally harmful to you. Because these are professional records written in technical language, they can be misinterpreted or can be upsetting, so if you request your records, then we recommend that you and your clinician review them together to discuss what they contain. Any notes the clinician may take for academic purposes contain no identifying information, and are not part of your protected health information (outlined in more detailed in the accompanying HIPAA document).

Authorization for Consent to Treat

By signing below, I hereby authorize PCA to carry out such assessment and treatment procedures as may be necessary for my care and also to process insurance claims on my behalf.

Client Signature ____ Date _______________________________

Client Name Printed _____________________________________

Witness Signature_______________________________________ Date _______________________________

Parent/Guardian Consent for Minors

I certify that I am the parent or legal guardian of ____

I hereby authorize PCA to carry out such assessment and treatment procedures as may be necessary for my child's mental health care.

Minor's Name (Printed) _________________________________ Minor’s Date of Birth __________________

Parent/Guardian's Name (Printed) ____

Parent/Guardian Signature ____ Date ______________________

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Notice of Privacy Practices - HIPAA

This notice describes how protected health information (PHI) about you may be used and disclosed and how you can access this information.

Our Contact

If you have any questions about this notice, please contact (251) 626-5797.

Our Pledge Regarding Your Protected Health Information

We understand that your PHI is personal. We are committed to protecting the privacy of this information. Each time you visit PCA, we create a record of the care and services you receive. We need this record to provide you with quality care, and comply with certain legal requirements. This notice applies to all records of your care generated by PCA. This notice will tell you about ways in which we may use and disclose PHI about you. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI.

Our Responsibilities

Our primary responsibility is to safeguard your PHI. We must also give you this notice of our privacy practices and we must follow the terms of the notice that is currently in effect.

Changes to this Notice

We reserve the right to change this notice, and we reserve the right to make the revised or changed notice effective for the PHI we have already collected as well as any information we receive in the future. We will post a copy of the current notice on premises.

Your PHI Rights

Although your health record is the physical property of PCA, the information belongs to you.

You have the right to: File a complaint, request a restriction, have a Copy of This Notice of Privacy Practice upon request, inspect, copy (according to Alabama Laws for charges of copies), review, request an amendment, accounting, confidentiality, revocation of your record.

If you believe your privacy rights have been violated, you may file a complaint in writing to: Lizette Turner, 29000 U.S. HWY 98, Suite A-102, Daphne, AL 36526. There will be no retaliation for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services, 200 Independence Ave SW, Washington, DC, 20201. You may request a restriction on certain uses and disclosures of your information. We are not required by law to agree to your request. If we do agree, we will comply with your request unless your information is needed to provide you with emergency treatment. You may request and inspect a copy of your PHI for a copying fee as required by Alabama State Law. We may deny your request under limited circumstances. If you are denied access to health information, you may request that the denial be reviewed by another behavioral health professional chosen by someone on our behavioral health team. We will abide by the outcome of that review.

You may request an amendment to your health record in writing if you feel the information is incorrect or incomplete. Your request must include a reason to support the request. Your request may be denied if the information was not created by our behavioral health team, is not part of the information kept by our facility, is not part of the information we are not permitted to copy (such as information we receive from other facilities), or if that information is not accurate and complete. Please note that if we accept the request, we are not required to delete any information from our record. You may obtain an accounting of disclosures of your health information. The accounting will only provide information about disclosures made for purposes other than treatment, payment, or health care operations. You may revoke your authorization to use or to disclose your PHI except to the extent that action has already been taken.

How we may use and disclose information about you

The following categories describe different ways that we use your PHI. We have not listed every use or disclosure within the categories but all permitted uses and disclosures will fall within one of the following categories:

Treatment-We may use PHI about you to provide you with treatment and services. We may disclose PHI about you to doctors, nurses, technicians, medical students, interns, or other personnel who are involved in taking care of you during your visit with us.

Payment-We may use and disclose PHI about you so the treatment and services you receive may be billed and payment collected from you. This may also include the disclosure of PHI to obtain prior authorization for treatment and procedures from your insurance plan.

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- Health Care Operations-We may use and disclose PHI about you for health care operations including quality assurance activities, administrative activities, PCA, financial business planning and development, customer service activities including investigation of complaints, and certain marketing and activities, etc. These uses and disclosures are necessary to operate our behavioral health practice and ensure all of our clients receive quality care.

- Appointment Reminders-We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment in our practice.

- With Specific Written Authorization- Other uses and disclosures of PHI not covered by this notice or the laws that apply to use will be made only with your written authorization. If you authorize us to disclose PHI about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have made with your permission, and that we are required by law to retain our records of the care provided to you.

Special Situations that do not require your consent or authorization

Military and Veterans -If you are a member of the Armed Forces, we may disclose PHI about you as required by military command authorities. Worker's Compensation-We may release PHI about you for worker’s compensation or similar programs if you have a work-related injury.

Averting Serious Threat -We may use and disclose information about you when necessary to prevent serious threat to your health or safety or the health and safety of another person or the public. These disclosures would be made only to someone able to help prevent the threat.

Public Health Activities -We may disclose PHI about you for public activities including the prevention or control of disease, injury or disability, to report births and deaths, to report child abuse or if we believe the client has been a victim of abuse (including elder abuse), neglect or domestic violence.

Health Oversight Activities-We may disclose PHI to a health oversight agency for activities authorized by law such as investigations, audits, inspections and licensure.

Lawsuits and Disputes -If you are involved in a legal dispute or lawsuit, we may disclose PHI about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute. We would only disclose this information if efforts have been made to tell you about the request to allow you to obtain an order protecting the information requested.

Law Enforcement, Coroners, Medical Examiners, National Security, Inmates -We may disclose PHI in emergency situations as required by law to law enforcement, coroners, medical examiners and/or to authorized federal officials for intelligence. If you are an inmate of a correctional institute, we mat disclose PHI about you so that you are provided with health care, to protect your health and safety, and the health and safety of others.

Client Signature ____ Date ___________________________________

Client Name Printed ____

Witness Signature ____ Date ___________________________________

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____ Date of Birth: __________________________

Previous Name: ____ Social Security #: _______________________

I hereby authorize **Professional Counseling Associates** to release information to the following organization and for the following person/organization to release information to **Professional Counseling Associates** for the coordination of treatment:

Physician/Facility Name: ____

Address: ____

Phone/Fax: ____

I understand that the purpose of the disclosure is to: □ Comply with client's request □ Coordinate treatment

The information to be disclosed includes but may not be limited to:

□ All mental health records □ Progress in treatment □ Attendance □ Participation □ Diagnoses

□ Evaluations □ Treatment Plan □ Alcohol and/or drug addiction treatment

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be re-disclosed by the recipient and at that time would no longer be protected by the original disclosing person or organization. I agree that a photocopy or facsimile of this authorization is as valid as the original. This authorization for release of information will expire in one year from the date signed.

Patient Signature: ____ Date signed: _________

Parent/Guardian: ____ Date signed: _________

Witness: ____ Date signed: _________

PROFESSIONAL COUNSELING & ASSOCIATES, LLC

ASHLEY C. SIMPSON, LPC, ACRPS
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29000 US HWY 98 SUITE A102 251-626-5797

PRE-AUTHORIZED CREDIT CARD PAYMENT FORM

Please complete this form *IF* you wish to have your credit card automatically charged for your office visit. We accept VISA and MASTERCARD.

I authorize ______________________ at Professional Counseling Associates, LLC to keep my signature on file and to charge my designated credit card account for current session charges.

This form is valid for one year. You must give 30 days written notice if you wish to cancel this agreement. Any outstanding balance will be paid in full at that time.

PATIENT NAME

NAME ON CARD

ACCOUNT NUMBER SECURITY CODE EXP DATE

CARDHOLDER ADDRESS CITY/STATE/ZIP

CARDHOLDER SIGNATURE DATE