Name: **DOB:** **Treatment ID:** **Record #:**

FACE SHEET

Name: _______________________________________ DOB: ____/____/_____ Gender: ______________

Address: ____ Town/City: ___________________________

State: _________________ Zip Code: ___________________ Social Security #: _______/_______/_________

Home Phone #: ____________________ Cell/ Work Phone #: _____________________________

Employer/ School Name: ______________________________ Occupation/ Grade: ___________________

Employer/ School Address: ____________________________ Annual Salary: ______________________

DEMOGRAPHIC INFORMATION:

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Pregnant ☐ Yes ☐ No

Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race ☐ Black or African American ☐ White ☐ Asian
☐ American Indian or Alaska Native ☐ Other: _________________________________

Number of Arrests in last 30 days: _______Last Substance Use in 30 days _______ Highest Level of School: _______

Living Arrangement: ☐ Home with Family ☐ Group Home / Number of People that Live in Your Home: _______

Military Service ☐ None ☐ Self ☐ Parent ☐ Spouse Rank and War, if Applicable: ______________________

How did you hear about AGC PLLC: ☐ Internet ☐ Word of Mouth ☐ Physician ☐ Other Professional Referral

Why have you come to counseling (Presenting issue)? ____

____

____

How long has this been an issue? ____

EMERGENCY CONTACT INFORMATION:

Name: ______________________________ Home Phone: ______________ Relationship: _____________

Cell/ Work Phone: _______________ Address: ____

CONSENT TO THE USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS:

I understand that my health information may be used and disclosed by Andrea Garraway Counseling, PLLC. to carry out treatment, obtain payment, and conduct healthcare operations. I have read and understood the Notice of Privacy Policy, provided by Andrea Garraway Counseling, PLLC., which gives a more complete description of uses and disclosures of health information. I hereby grant the medical personnel of Andrea Garraway Counseling, PLLC permission to release health information acquired in the course of my examination and treatment to the appropriate parties, with all due discretion, when necessary for treatment, payment, healthcare operations, and emergency purposes. I understand that the medical personnel at Andrea Garraway Counseling, PLLC. will communicate, on a regular basis, with other treating health care providers. All records are kept confidential and shared only with pertinent personnel involved. I understand that I have the right to request restrictions on how health information may be used or disclosed, but that the provider designated is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the provider has taken action in reliance on the consent. I agree that this consent shall be valid until rescinded in writing or replaced in writing by one at a later date.

Signature: ____ **Date:** _____________________

THE INFORMATION RELEASED IS CONFIDENTIAL AND REDISCLOSURE IS PROHIBITED
EXCEPT AS AUTHORIZED BY G.S. 122C-53 THROUGH G.S. 122C-56.

ANDREA GARRAWAY COUNSELING PLLC

Name: **DOB:** **Treatment ID:** **Record #:**

INFORMED CONSENT

1- I /we give consent to Mental Health and/or Substance Use services provided by Andrea Garraway Counseling PLLC.
2- I /we acknowledge that this service is voluntary and that I /we may discontinue services at any time.
3- I /we agree to be photographed or video recorded by Andrea Garraway Counseling PLLC, for diagnostic or therapeutic purposes. I /we understand that confidentiality will be guaranteed in the use of this material, that I /we are not required to give permission for the consumer(s) to receive services, and that I /we may revoke consent at any time by amending this Admission Agreement.
4- I /we understand that the right to participate in the development of the plan of services to be offered, and to be informed of the expectations of all parties involved in the implementation.
5- I / we recognizes individual and couples counseling sessions last approximately 50 minutes and full participation is important to achieving the goal(s). Group counseling sessions are 90-minutes and differs between closed and open formats. Homework may be assigned to support the counseling process for both individual and/or group.
6- I /we acknowledge confidential information may be disclosed to persons responsible for conducting general research or clinician, financial, or administrative audits if there is a justifiabledocumented need for this information. A person receiving the information may not directly or indirectly identify any individual in any report of the research or audit or otherwise disclose the individual's identity in any way.
7- I /we can find and access the notification of HIPAA ACT on the Andrea Garraway Counseling PLLC website.
8- I /we aware all consumers have the right to voice concerns regarding their treatment and the services they are being provided. You are encouraged to discuss this with your therapist. If at any time you feel that we have not addressed your needs and/or concerns, please feel free to contact:

Post Office Box 77819
Greensboro, North Carolina 27417
844-622-3572 or 336-217-6007
E-mail: LCMHCinfo@ncblcmhc.org
(http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx).

8. I /we agree that this document may be amended on an as-needed basis, and that any such amendment will require the signature of the consumer(s) and duly authorized personnel of Andrea Garraway Counseling PLLC.

9. Exceptions and additions to consent:
____

____________________ ____________________
Date (Consumer/Legal Guardian)

____________________ ____________________
Date (Partner/Legal Guardian)

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ANDREA GARRAWAY COUNSELING PLLC

Name: **DOB:** **Treatment ID:** **Record #:**

PROFESSIONAL DISCLOSURE STATEMENT

The purposes, goals, and treatment procedures of the psychological services to be provided will be explained to me. I understand that my therapist is licensed in the state of North Carolina and New York to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise. While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Andrea Garraway Counseling PLLC. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

CONFIDENTIALITY

I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person, or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena (ordered by a judge or magistrate) and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case.

MISSED APPOINTMENT POLICY

I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the rate of $80 per missed appointment. Further, I understand that my insurance will not cover these charges in any way, and I will be liable for all charges that result from a missed appointment without sufficient (24 hour) notice. In addition, if I miss more than two appointments in an 8-week period, a subsequent appointment time cannot be guaranteed.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment. I release and hold harmless Andrea Garraway Counseling PLLC, and its staff and agents from any action or liability arising out of my participation in treatment.

__________________________ ______________________________

Date (Consumer/Legal Guardian)

__________________________ ______________________________

Date (Partner/Legal Guardian)

ANDREA GARRAWAY COUNSELING PLLC

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EXCEPT AS AUTHORIZED BY G.S. 122C-53 THROUGH G.S. 122C-56.