COMMUNITY COUNSELING CENTER

Client Information Form

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____

Home Street Address: _____

City: _____ **State:** _____ **Zip code:** _____

Home Phone: _____ **Cell Phone:** _____
Can messages be left? **Y N** Can messages be left? **Y N** Can text be sent? **Y N**

Email: _____
Do you consent to email communication? **Y N**

Preferred Method of Communication: Cell Phone Text Email Home Phone

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature)

_____

Insurance Information

Name of Primary Insured: _____ **Date of Birth:** _____

Insurance Company: _____ **& ID#:** _____ **EAP Confirmation #:** _____
If Applicable

Name of Employer: _____

Referred by: _____

Presenting Concerns

Please briefly describe your presenting concern(s): _____

_____

_____

_____

Demographics

Race/Ethnicity: _____ Were you born in the US?: **Yes No**

Sexual Orientation: **Heterosexual Gay Lesbian Bisexual Other** _____

Gender: **Female Male Transgender Other** _____

Religious Affiliation: _____

Is religion/spirituality important to you? **Yes No Somewhat**
If so, how does it affect you?

_____

Work and Education

Are you currently employed? **Yes** **No** Current Position:_____
Highest degree obtained: _____ Are you currently a student?: ____ Where?: _____

Relationships and Family:

Current Relationship Status

☐ Single	☐ Married	☐ Life Partner	☐ Separated	☐ Divorced	☐ Widowed

Relationship Satisfaction: Poor 1 2 3 4 5 6 7 8 9 10 Excellent Describe the quality of your relationship: _____

_____

Name of spouse/partner/significant other: _____
Do you have children? _____ Ages:_____ Are you currently having any issues with your children?: _____

Medical and Mental Health History:

Primary Medical Doctor :_____ Date of last check up:_____
Please explain any significant medical problems, symptoms, or illnesses: _____

_____

Do you exercise? **Yes** **No** If yes, how often? _____
What activities/hobbies do you enjoy?_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? **Yes** **No** If YES, how much per day? _____
Do you consume caffeine? **Yes** **No** If YES, how much per day? _____
Do you drink alcohol? **Yes** **No** If YES, how much per week? _____
Do you use any drugs? **Yes** **No** (Please remember that this form is confidential)
If Yes, what kinds and how often? _____

_____

Recent or Significant Medical Hospitalizations: (Approximate dates and reasons): _____

_____

_____

Have you been in therapy in the past? **Yes** **No**

(Please list approximate dates and reasons): _____

_____

_____

How would you describe your therapy experience? _____

Have you ever attempted suicide in the past? Yes No
(If yes, please list approximate dates)

_____

Have you ever been hospitalized for mental health reasons? Yes No
(If yes, please list dates and reasons)

_____

Are you currently taking any medications for mental health? Yes No
(If yes, please list including dosage) _____

_____

PLEASE CHECK ALL THAT APPLY :

Difficulty with	Now	Past	Difficulty with	Now	Past	Difficulty with	Now	Past
Anxiety			People in general			Nausea		
Depression			Marriage/partner			Abdominal distress		
Mood changes			Parents or children			Dizzy		
Panic			Friends			Fainting		
Excessive worry			Coworker			Diarrhea		
Fear			Employer			Chest pain		
Irritability			Finances			Shortness of breath		
Concentration			Legal problems			Sweating		
Headaches			Alcohol			Heart palpitations		
Loss of memory			Drugs			Muscle tension		
Feeling manic			Caffeine			Weight gain		
Gender identity			Blackouts			Weight loss		
Sexual identity			Sleep too little			Eating problems		
Racial identity			Sleep too much			Frequent vomiting		
Domestic violence			Trouble waking			Making careless mistakes		
Hyperactivity			Nightmares			Thoughts of hurting someone		
Assertiveness			History of sexual abuse			Hurting self		
Learning Disorder			History of child abuse			Thoughts of suicide		
Head injury			Sexual problems			Anger or temper		

FAMILY HISTORY OF: (check all that apply)

Drug/Alcohol Problems		Physical abuse		Depression	
Legal trouble		Sexual abuse		Anxiety	
Domestic violence		Hyperactivity		Psychiatric hospitalization	
Suicide		Learning disability		"Nervous breakdown"	

Any additional information you would like to share: _____

_____

_____

_____

LCSW Professional Disclosure Statement

Elizabeth Hartman, LCSW
Community Counseling Center, 4810 Wrightsville Ave., Wilmington, NC 28403
910-452-7370 Fax 910-798-5199

Licensed Clinical Social Worker in North Carolina (#C009407)
Practicing psychotherapy since 2007
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Bachelor of Arts in Sociology and Communication, Wake Forest University, 2002
***
Master of Science in Social Work, Columbia University, 2007

General Scope: I provide counseling and psychotherapy to adults, 18 years and older without regard to race, gender, sexual orientation, or religious affiliation. I offer treatment for a variety of presenting issues including depression, anxiety, relationship issues, stress, grief and loss, trauma, and life transitions. I also offer treatment for eating and substance use issues provided the client is also receiving necessary medical/psychiatric care.

Therapy Sessions: I use a combination of interpersonal theory and cognitive behavioral therapy, dialectical behavioral therapy, and mindfulness to tailor my therapeutic approach to individual clients. The initial interview typically takes places over 1-2 sessions and typically consists of past family, social, medical, and work history and current supports and concerns. At times your presenting concerns may not be within my scope of expertise and practice. I will then provide referrals to help you get the appropriate care. At the start of treatment, you and I will work together to create a treatment plan based on your goals. I will review these goals in session peridocially to ensure that we are making progress and that the goals have not changed. This treatment plan may include a diagnosis which will become part of the confidential treatment record. I refer clients to a primary care physician or psychiatrist when there is need for medication or psychiatric evaluation. When psychological testing is needed, I refer clients to a clinical psychologist.

Confidentiality: The content of all sessions is completely confidential, as are the records of treatment. Please note that I may discuss cases, without using specific identifying information, in peer supervision to help me provide more effective therapy. Peer supervision is clinical consultation with another licensed clinician who is also bound to keep client information confidential. By signing this agreement, you give permission for these discussions. Outside of peer supervision, I will not disclose information regarding a client unless authorized to do so by the client in writing through a release of information. **Exceptions to confidentiality** are when a client indicates potential physical harm to self and/or others, when reported or suspected child or elder abuse or neglect is shared by a client, when a court order requires producing records, or when needed for insurance purposes. I will make an effort to notify the client before sharing records for any of these reasons.

Fees: When clients are using insurance, the Center will accept allowable amounts per insurance plan. Clients are responsible for co-pay and deductible costs. For self-pay/out-of-network clients, the charge per session is $135. When a client is unable to afford the fee, reduced fees are available through the financial support of local organizations and individuals. Reduced fees are negotiated on an individual basis. The fee we have set for sessions in this case is $_____. Payment is required at time of service. The Center accepts cash, personal checks and credit cards. All other services, including in depth phone calls, letters, forms, telephone consultation, meetings attended on your behalf and at your request (including travel time) are billed at the rate of $40 per 15-minute increment. Insurance does not cover these services. The court system has certain protections for the confidential therapeutic relationship; however, if I am subpoenaed or my involvement is requested then additional fees will apply.

Cancellations/no-shows/tardiness: The full fee is charged for missed appointments and appointments cancelled with less than 24-hours' notice. This charge is the sole responsibility of the client. If clients do not show for 2 appointments or late cancel 3 times, this will be grounds for ending the therapy sessions. Therapy is most effective when you can find a way to make it one of your priorities and committing to attending sessions helps you to prioritize this time for self-care and personal growth. Of course, there can be extenuating circumstances that can cause both you and me to be absent at times. There will be no charge if: (1) you are ill or your child is ill, (2) you experience an emergency, (3) driving conditions are hazardous because of inclement weather.

Phone Messages: During regular office hours, calls are answered by office staff or Elizabeth when not in session. In the evening, calls will go to voicemail. Elizabeth/office staff attempt to return calls within 24 hours. However, if you call and do not receive a call back within 24 hours during the work week, please call again. If you leave a message to cancel an appointment, Elizabeth will leave it up to you to call back when you are ready to reschedule.

Email: CCC prefers use of emails primarily for office procedures, billing practices, or administrative matters. CCC has a general office email address but please do not use it for content related to therapeutic matters. You may email me, but emails should contain non-urgent and non-confidential matters. If you are experiencing an emergency my private voice message at CCC has information on how to contact me after hours. If it is a mental health emergency, call 911 or the crisis line:1-844-709-4097

Social Media: I do not accept friend or contact requests from current or former clients on any social networking site (e.g., Facebook). Adding clients as friends on these sites can compromise your confidentiality and blur the therapeutic relationship.

Ending Therapy: Generally, therapy ends when you have accomplished the goals we established at the beginning of therapy. If possible, I encourage scheduling a last session as it can be helpful to review goals and a way to honor the work you have done in the sessions. If therapy is not working for you, then I would encourage you to talk about this in session. If you stop attending sessions, I understand that sometimes it is just not the right time to devote the energy necessary for successful therapy. I may call to ensure your wellbeing, but I will not call again out of respect for your choice. If you decide at a later date that you are ready to restart therapy, then you are more than welcome to make another appointment. Any complaints regarding treatment can be directed to North Carolina Social Work Certification and Licensure Board, PO Box 1043, Asheboro, NC 27204. Phone: 336-625-1679 x222 Fax: 336-625-4246, jtarlton@ncswboard.org.

I have thoroughly read this document and give my consent for treatment. I have read and understand the policies and agree to the conditions. If CCC is assisting in filing insurance claims, I also authorize Elizabeth Hartman, LCSW and CCC on her behalf, to release any and all information to assist in filing my claim with insurance. I authorize payment of benefits to CCC for psychotherpay services rendered. If an insurance claim is denied, I agree to pay the balance in full. I understand I have the right to withdraw from treatment at any time.

Client _____ Date _____

Therapist _____ Date _____

COMMUNITY COUNSELING CENTER
Jonathan R. Kelley, D.Min., LPC
Susan Lewis, LCSW
Ben T. Rigby, Ph.D., LP
Elizabeth Hartman, LCSW
4810 Wrightsville Avenue
Wilmington, NC 28403
(910) 452-7370

CONSENT TO RECEIVE TREATMENT

I give my consent to receive counseling at the Community Counseling Center.

I accept financial responsibility for every appointment I make, and I agree to pay for each session each time service is rendered.

I agree to pay for any missed appointments for which I do not give 24-hour notice of cancellation.

I acknowledge I have received copies of the Center's Notices of Privacy Practice (Brief and Complete), and I have been given opportunity to ask questions about these Notices.

Signed _____ Date _____

Witness (Administrative Assistant or Counselor) _____

Parental/Guardian Consent (***If client is under age of 18):***

I _____ certify that I have legal custody or that I am the legal guardian for medical consent purposes of _____. I give permission for him / her to receive treatment.

Parent/Guardian _____ Date _____

Witness (Administrative Assistant or Counselor) _____