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: _____

_____

_____

_____

Consent for Treatment and Professional Disclosure Statement

Ben T. Rigby, Ph.D., Licensed Psychologist in North Carolina (#4093)
Community Counseling Center
4810 Wrightsville Ave., Wilmington, NC 28403

As a staff member of the Community Counseling Center (hereafter CCC), Dr. Rigby provides psychological services to individual children, adolescents, and adults, as well as to couples, families, and groups without regard to race, gender, sexual orientation, or religious affiliation. Dr. Rigby offers psychotherapy for a variety of concerns including depression, anxiety, relationship/marital conflict, parenting, stress, AD/HD, Autism Spectrum, and unwanted behaviors. He also offers consultations for individuals who are not seeking psychotherapy but who wish to work with a psychologist to provide them with information, guidance, and/or support in goal setting, decision-making or in discerning a more productive way to interact with family member(s) or work colleague(s). These types of consultations are not considered psychotherapy, do not involve a diagnosis, and cannot be billed to insurance.

In the context of psychotherapy, Dr. Rigby primarily uses cognitive-behavioral therapy (CBT) techniques, including acceptance and commitment therapy (ACT), as well as positive psychology and mindfulness techniques all of which are tailored to meet individual client's needs. The initial intake/diagnostic interview usually takes place over the first 1-2 sessions. At the start of treatment, the client [and/or parent(s)/legal guardian(s)] and Dr. Rigby will make a treatment plan based on the client's reported symptoms and concerns. This treatment plan will likely include a diagnosis, which will become part of the client's confidential records. Dr. Rigby will refer clients to a primary care physician or psychiatrist when there is need for medication or psychiatric evaluation. When psychological evaluation is needed, he will typically refer clients to a psychologist who specializes in providing psychological evaluations.

The content of all sessions is completely confidential, as are the records of treatment. Please note that Dr. Rigby may discuss cases in peer supervision and by signing you give permission for these discussions, when consultation is to aid him in providing effective therapy. Peer supervision is clinical consultation with another clinician at the Community Counseling Center, who is also bound to keep client information confidential. Outside of peer supervision, Dr. Rigby will not disclose information regarding a client unless authorized to do so by the client in writing. 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 reported, when a court order requires producing records, or when needed for insurance purposes. Dr. Rigby will make an attempt 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. For self-pay/out-of-network clients, diagnostic interview sessions are $150 each and psychotherapy sessions are $135 each. When a client is unable to afford the fee, reduced fees are available through the financial support of local organizations, churches, and individuals who are donors to this Center. Reduced fees are negotiated on an individual basis and are recorded on an addendum document. Payment is required at time of service. The CCC accepts cash, personal checks and credit cards. Without 24-hour notice, the full fee is required for missed sessions. The CCC will bill clients' insurance companies if such coverage is available. Clients are responsible for co-pay and deductible costs. All other services, including phone calls, letters, telephone consultation, meetings attended on your behalf and at your request (including travel time) are billed at the rate of $50 per 15-minute increment. Insurance does not cover these services. Testifying: Participating in court for custody or any other matter is not an expected service. Should Dr. Rigby be subpoenaed, the rate is $300 per hour or $2000 total, whichever amount is greater, for all time related to responding to the subpoena regardless of whether he is called to testify. This may include time reviewing notes and talking with attorneys, as well as any phone calls or letters written on your behalf. If required to appear in court, he must cancel all other clients for that day, even when placed on "stand-by" status. You will be charged for the entire day. The rate is the same for depositions of fact or expert witness, as well as testimony. The party sending the subpoena is responsible for the entire bill. Preparing an affidavit will cost $500 or $300 per hour, whichever is greater.

Cancellations and no-shows: There is a charge for missed appointments and appointments cancelled with less than 24-hours' notice. This charge is the sole responsibility of the client. Clients who do not show for two scheduled appointments will not be rescheduled. Clients are most successful in therapy when they find a way to make it one of their priorities, and committing to attending sessions helps clients to prioritize this time for personal growth. The full fee is charged for intake, therapy, and consultation appointments that are missed or cancelled less than 24 hours in advance. However, there will be no charge if: (1) you are ill, (2) you experience an emergency, (3) driving conditions are hazardous because of inclement weather.

Late Fees & Returned Checks: The returned Check fee is $30. If you do not pay in full on the date services are rendered and no prior arrangements were made, 10% of the original charge will be added each week you are late. Regarding

delinquent accounts, you are responsible for, in full, and will be charged for, in full, any fees due and/or any and all fees of any outside services hired to collect the debt.

Separation/Divorce Policy: The parent who initiates services will be held financially responsible. CCC does not bill another person or former spouse unless we are notified in writing of his or her willingness to pay for rendered services.

Children & Treatment Consent: To provide consent for treatment for a child you must either have sole legal custody OR shared legal custody OR legal guardianship. If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, then Dr. Rigby's services fall under this, and you may be in violation of a court order if you fail to inform the other parent of Dr. Rigby's services with your child. By signing this form you are stating that you have the legal right to consent for this child's treatment. Unless parental rights have been terminated, either parent is entitled to access to his/her child's therapist and to participate in their child's therapy, as appropriate.

Request for Records: Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in securing and maintaining that trust. By signing this agreement, you will be waiving your right to access your or your child's treatment records except for treatment summaries provided upon request. If Dr. Rigby is required to testify, a judge may order Dr. Rigby to produce records. A subpoena signed by an attorney will not be enough for us to release your child's therapy records.

Phone Messages: During regular office hours calls are answered by office staff or Dr. Rigby, when not in session. In the evening, calls will go to voicemail. Dr. Rigby/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, Dr. Rigby 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. Emails should contain non-urgent matters only. If you are experiencing an emergency Dr. Rigby's private voice message has information on how to contact him after hours. If it is a dire emergency, call 911 or go to the closest emergency room.

Social Media and Text Messages: Dr. Rigby does not accept friend or contact requests from current or former clients on any social networking site (e.g., Facebook). As a general rule, Dr. Rigby does not accept text messages. Adding clients as friends on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Ending Therapy: Generally, therapy ends when you have accomplished the goals we established at the beginning of therapy; however, therapy can be ended at any time by either the client or the therapist. If you stop attending sessions, Dr. Rigby understands that sometimes it is just not the right time to devote the energy necessary for successful therapy and he generally will do not call out of respect for your choice. If you decide at a later date that you are ready to become involved in therapy again, please feel free to call and ask to resume therapy. If you are unhappy with therapy, please share your concerns directly with Dr. Rigby and perhaps changes can be made to make therapy more helpful to you. Complaints regarding treatment can be directed to: North Carolina Psychology Board, Executive Director, 895 State Farm Road, Suite 101, Boone, NC 28607.

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 Ben T. Rigby, Ph.D., and CCC on his behalf, to release any and all information to assist in filing my claim with insurance. I authorize payment of benefits to CCC for psychological services rendered. If an insurance claim is denied, I agree to pay the balance in full.

Client _____ Date _____

Parental or Guardian consent for client under age 18: I _____ certify that I

have legal custody or am the legal guardian for medical purposes for _____ (child's name). I give me permission for him/her to receive treatment.

Parent/Guardian _____ Date_____

Therapist _____ Date _____