DATE:________________________

Personal Information for Adult and/or Guarantor

(Please print and complete all requested information on front and back of this form)

Name:____Name You Prefer__________________________________

Address:____City:_________________________State:_________Zip:___________

Sex: M_____F_____ Age _______Birth Date ____/____/_________ Soc. Security No. _________ /_____ /_______

Status (Please Circle): Single Married Separated Divorced Partnered Widowed

Name and Age of Children: _____________________________________Age____, ____Age_____,

____Age___, ___________________________Age, ______________________________Age___

_____Employed ______Unemployed Employer ____Occupation__________________

Religious Affiliation____Congregation Name_________________________________

List of Physicians you have seen in the last 24 months:____

Previous Psychiatrist / Counseling ? _____Yes _____No If yes, When___/____/____ With Whom _________________________

Concerns that bring you here____

ANY KNOWN DRUG ALLERGIES:____

Prescription and non-prescription medications you take____

Amount of Alcohol (Beer, Wine, Mixed Drinks) you use each day__________________Week____________________________________

Who Referred you? Please check appropriate referral

Medical Provider_______Internet_______ Church________Insurance Co_________ Previous Client_________ Other _________

Other____ (Specify name of referral)

May we call you? ________Home_____Work_____Other____

Home Phone (   ) ____________________ Work Phone (   ) __________________Ext No. _____ Other___________________

When is the best time to reach you? Time: __________________________ Days____

Emergency contact:________________________ **phone number**______________________________

Revised 3/2018

PRIMARY INSURANCE

Name of Policy Holder____ Relationship to client_____________________________

Policy Holder's Birth Date________ ________ _________ Social Security No. _________ ________ ____________________

Employer Name and Address____

Employer's phone ( )____

Insurance Company Name and Address ____

Insurance Company phone ( )_________________________________

Policy No. ____ Group No.____

Secondary Insurance

Name of Policy Holder____ Relationship to client_____________________________

Policy Holder's Birth Date________ ________ _________ Social Security No. _________ ________ ____________________

Employer Name and Address____

Employer's phone ( )____

Insurance Company Name and Address ____

Insurance Company phone ( )_________________________________

Policy No. ____ Group No. ____

Responsible Party Other Than Client

Name and Address____

Relationship____ Employer ____

Work Phone ( )__________________________________ Home Phone ( )____

Rights and Responsibilities

The purpose of counseling is to help you clarify your goals and to achieve greater understanding and skills so you can reach your goals. Much of the success of counseling will depend on your willingness to participate fully in the process of developing goals that are significant to you. Your therapist's role will be to help you develop options for how you want to reach your goals. If you feel dissatisfied with any part of our work together, please let your therapist know immediately so your therapy will be as productive as possible. If you believe you have been treated unethically, by any counselor, and cannot resolve this issue with that person, you may contact the North Carolina Board of Licensed Professional Counselors at (919) 661-0820, North Carolina Marriage And Family Therapy Licensure Board (336) 794-3891, or North Carolina Social Work Certification and Licensure Board (800) 550-7009 or (336) 625-1679 for clarification of your rights or to lodge a complaint.

Authorization for Insurance & Consent for Services

I, the undersigned, have insurance coverage with ____ and assign directly to Presbyterian Counseling Center all medical benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance company. I hereby authorize Presbyterian Counseling Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I hereby give my consent for treatment for myself and/or my child for services to be provided by Presbyterian Counseling Center. I understand that I may discontinue at any time. I have read the Presbyterian Counseling Center Information sheet and certify that the above information is correct.

____ _______ ____________ _________________

Signature of Insured/Guardian/Responsible Party Date

Revised 3/2018

Presbyterian Counseling Center
HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Healthcare Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family or other contact? YES NO

If YES, please name them members allowed:

Name	Relationship	Date
Name	Relationship	Date
Name	Relationship	Date

This consent was signed by:

Print name please

Signature: Date

Witness: Date

Revised 1/2018

Presbyterian Counseling Center
Privacy Practices

This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Mental Health Information Rights

Request Restrictions: You may request further restrictions on our uses and disclosures of your mental health information. We may not be able to agree to all requested restrictions. Please let us know if you want specific restrictions on your information.

Different Ways to Communicate: We will usually communicate by mailing or phoning your residence. However, you may prefer a different way for us to contact you. For example, you may ask for us to contact you at a specific address or phone. Please note that cell phones and e-mail may not offer confidentiality or privacy protection.

Right to Inspect and Copy Information: You may inspect and copy your mental health information. We may charge for copying. To inspect or copy your mental health information, you must make your request in writing to the Privacy Officer. There are situations in which we do not have to comply with your request. However, we will state in writing if we cannot comply with a request.

Right to Request Amendment of Your Information: You may request that your mental health information be amended or changed. We may deny your request if we did not create the information (it was obtained from another source). Also, we may deny your request if we believe the information is correct. Denials will be written and will describe your rights for further review. If we agree to amend, we will make reasonable efforts to share with any person who may have received your mental health information that it needs amending.

Listing Of Disclosures We Have Made: You may request a copy of certain disclosures we have made of your mental health information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request in writing to our Privacy Officer.

Copy of This Notice: You may request a copy of this notice at any time. A copy is available at our web site, www.greensboro.com/pcc

How Your Mental Health Information May be Used

Except for the following purposes, we will use and disclose your mental health information only with your written permission. You may revoke such permission at any time by writing our Privacy Officer.

Treatment: We may use your information and disclose it to manage or coordinate treatment provided to you. For example, your therapist may share information with another therapist or your physician to coordinate services

Payment: We may use and disclose necessary information about you to obtain payment for our services. For example, this information could include information that your health insurance plan may require before it approves or pays for treatment services we recommend for you.

Health Care Operations*:* We may need to use or disclose information for our practice activities. Examples of these activities include: quality assessment to see how well we are doing in serving individuals, couples, and families; clinical supervision of staff to meet state licensure and/or certification requirements.

We may use or disclose information about you in several other circumstances in which you do not have an opportunity to agree or object. These situations include:

Required by Law*:* We may need to disclose information for judicial or other administrative proceedings. For example, we may need to disclose information in response to a court order.

Abuse or Neglect: We are required to disclose information if we believe that you or a family member has been a victim of abuse or neglect

Danger to Self or Others: We are required to take steps to prevent you harming yourself or another person.

Law Enforcement: We may be required by a law enforcement official to provide information if it is in response to a court order, subpoena, warrant, or summons pertaining to victims of crime.

Public Health: We may be required by law to report health related information. These activities may include disclosures to prevent or control disease.

Complaints: If you think we have violated your privacy rights described in this notice, or you want to discuss with us about our privacy practices, you can contact: Dr. Robert Herron, Presbyterian Counseling Center, 3713 Richfield Rd., Greensboro, NC, 27410. Phone: 336-288-1484.

Also, you may send a written complaint to the U. S. Department of Health and Human Services, at 1-866-627-7748. If you send a complaint, we will not take any action against you or change our treatment of you in any way.

Revised 1/2018

Name: ____Date: __________________________

Brief Mood Survey*

Instruction: Use an X to indicate how you've been feeling over the past week, including today.
Please answer all items.

Depression

	Not at all	Somewhat	Moderately	A lot	Extremely
1. Sad or down in the dumps					
2. Discouraged or hopeless					
3. Low self-esteem					
4. Worthless or inadequate					
5. Loss of pleasure or satisfaction in life					

Total items 1 – 5 _____

Suicidal Urges

	Not at all	Somewhat	Moderately	A lot	Extremely
1. Do you have any suicidal thoughts?					
2. Would you like to end your life?					

Total items 1 – 2 _____

Anxiety

	Not at all	Somewhat	Moderately	A lot	Extremely
1. Anxious					
2. Frightened					
3. Worrying about things					
4. Tense or on edge					
5. Nervous					

Total items 1 – 5 _____

Anger

	Not at all	Somewhat	Moderately	A lot	Extremely
1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					

Total items 1 – 5 _____

Violent Urges

	Not at all	Somewhat	Moderately	A lot	Extremely
1. I've had thoughts or fantasies of hurting people					
2. I've had the urge to do something harmful or violent					

Total items 1 – 5 _____

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