

Kimberly Bolen McGrew, MA, LPA, LCAS-A *Clinical Psychologist*
Kimberly Bolen, PLLC

CONFIDENTIAL CLIENT INFORMATION

Welcome! Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal law, any information you provide is strictly confidential.

Demographic Information:

Client Name: _____ SSN: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ What is the best way to contact you? _____

Is it okay to leave a message? Yes / No May we email and text appointment reminders? Yes / No

Ethnic Group: _____ Religious Preference: _____

Parent(s) Name (if relevant): _____ Sex: M F

Address: _____ Telephone: (____) _____

Referral Information:

How did you find out about Kimberly Bolen McGrew, MA, LPA, LCAS-A? ☐ Google Ad

☐ Google Search ☐ Psychology Today Profile ☐ Network Therapy Profile ☐ Website

☐ Referred by _____ ☐ Other: _____

Please indicate if your therapist can thank the person/practice that referred you for therapy services. This verbal or written thank you note would not include any clinical or diagnostic information: ☐ Yes ☐ No

***If you authorize your therapist to thank the person/practice that referred you, please sign below to consent:**

Minor Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Emergency Contact Information:

Name: _____ Phone #: _____ Relationship: _____

*Completion of this section indicates permission to contact these people should an emergency arise (as determined by Kimberly Bolen McGrew, MA, LPA, LCAS-A). If you choose not to complete this section, should an emergency arise, I will contact 911.

Client Appointment Access:

Do you want anyone to be able to schedule or cancel appointments for you? Yes / No

Who? Name: _____ Phone #: _____ Relationship: _____

Client's Employment Information:

Are you currently employed? Yes / No

If yes, where are you employed? _____

What is your job title? _____

Client's Education Information:

Highest Level of Education/Grade Completed: _____

Are you currently a student? Yes / No

If yes, where? _____ Current Grade/Year in School: _____

Major (if applicable): _____

Client's Health Information:

Please list all past and current chronic illnesses, injuries, medical conditions or disabilities:

Allergies/Adverse Reactions to Treatment: _____

Primary Care Physician Name: _____

Name of Doctor's Office/Facility: _____

Approximate Date of Last Visit with Primary Physician: _____

May Kimberly Bolen McGrew, MA, LPA, LCAS-A coordinate care with your primary physician?

Yes / No Primary Physician Address: _____

Primary Physician Phone Number: (_____) _____

Client's Current Medications and Supplements:

Please specify on the chart below:

Please list all medications for medical and psychiatric/mental health conditions.

Current Medications & Supplements	Daily Dose	Start Date	Prescriber

Family/Significant Others Mental Health and Medical History:

Does anyone in your family have a history of the following? (Please check all that apply)

Mental Illness _____ Substance Abuse _____ Eating Disorder _____

Please specify on the chart below:

Please provide the following information about your **family members who have any mental health or medical conditions** (if applicable, include parents, stepparents, all siblings, spouse, children, etc.).

Name	Relationship to Client	Age	Mental Health/Medical Conditions

Client's Mental Health History:

Have you received counseling before? Yes / No

If yes, when, where, and with whom? _____

Please list any known previous mental health diagnosis: _____

What reason did you attend counseling before? _____

Please list any hospitalizations for psychological, psychiatric, or chemical dependency treatment, including location and dates: _____

Have you ever attempted suicide? Yes / No

If yes, what was the date of your most recent attempt? _____

Client's History of Substance Use:

Do you use alcohol? Yes / No If yes, what is the date of last use? _____

Average amount of alcohol consumed per occasion: _____

Frequency of alcohol consumption: _____

Do you use any other drugs? Yes / No

If yes, please list all drugs consumed: _____

If yes, what is the approximate date of last use? _____ Amount? _____

Frequency of drug use: _____

Do you drink caffeine? Yes / No If yes, how many cups/doses per day? _____

Do you use tobacco? Yes / No If yes, how many cigarettes per day? _____

Are you currently in recovery? Yes / No If yes, how much time clean and sober? _____

Have you ever experienced any of the following? (Please check all that apply):

Physical Abuse _____ Sexual Abuse _____ Sexual Assault _____ Verbal/Emotional Abuse _____

Have you experienced any recent and/or important loss? Yes / No

If yes, please specify: _____

Client's Goals to Accomplish in Therapy:

- 1) _____
- 2) _____
- 3) _____

Client's Current Issues/Concerns (Please check all that apply to you):

- | | |
|---|---|
| <input type="checkbox"/> Romantic Relationships | <input type="checkbox"/> Self-Confidence/Self-Esteem |
| <input type="checkbox"/> Family Relationships | <input type="checkbox"/> Body Image |
| <input type="checkbox"/> Peer Relationships | <input type="checkbox"/> Eating Disorder/Eating Issues |
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual Abuse/Molestation |
| <input type="checkbox"/> Loneliness/Social Isolation | <input type="checkbox"/> Sexual Assault |
| <input type="checkbox"/> Lack of Motivation | <input type="checkbox"/> Other Traumatic Event |
| <input type="checkbox"/> Feelings of Guilt | <input type="checkbox"/> High Energy |
| <input type="checkbox"/> Feelings of Hopelessness | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Sleep Problems (too much/too little) | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Memory Difficulties |
| <input type="checkbox"/> Feeling Overwhelmed | <input type="checkbox"/> Problems at Work/School |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anger Management |
| <input type="checkbox"/> Fears/Phobia | <input type="checkbox"/> Homicidal Feelings |
| <input type="checkbox"/> Doing Things Over and Over | <input type="checkbox"/> Suicidal Feelings |
| <input type="checkbox"/> Unwanted Habits | <input type="checkbox"/> Self-Harm |
| <input type="checkbox"/> Panic | <input type="checkbox"/> Hearing Voices |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Thoughts that Scare Me |
| <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Racial/Cultural Issues |
| <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Gender or Sexual Identity Issues |
| <input type="checkbox"/> Career Planning | <input type="checkbox"/> Grief/Loss |
| <input type="checkbox"/> Unemployment | <input type="checkbox"/> Physical Health Concerns |
| <input type="checkbox"/> Academic Performance | <input type="checkbox"/> Pregnancy (past, present) |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Spirituality Concerns |
| <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Trouble Making Decisions |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Other: _____ |

Clinical Information:

What type of services are you seeking/expecting? (Please check all that apply to you):

Individual Counseling _____ Group Counseling _____ Couples/Family Counseling _____

How well are you getting along psychologically at this time?

___ Very well, the way I want to.	___ So-so, can keep going with effort.
___ Quite well, no important complaints.	___ Quite poorly, can barely manage.
___ Fairly well, but have ups and downs.	___ Very poorly, don't think I can manage.

Is there any other relevant information that you would like for your therapist to know? _____

Primary Insurance Information:

Insurance Company Name: _____

Subscriber ID #: _____ Group #: _____

Name of Primary Insured Subscriber: _____

Relationship to Client: Self Parent Spouse Other: _____

Subscriber Social Security Number: _____ Subscriber DOB: _____

Secondary Insurance Information (if applicable):

Insurance Company Name: _____

Subscriber ID #: _____ Group #: _____

Name of Primary Insured Subscriber: _____

Relationship to Client: Self Parent Spouse Other: _____

Subscriber Social Security Number: _____ Subscriber DOB: _____

Signatures on Next Page

ALL CLIENTS: ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical and mental health/behavioral health/psychotherapy benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Kimberly Bolen McGrew, MA, LPA, LCAS-A and Kimberly Bolen, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that my signature requests that payment be made by my insurance company for services rendered and that I am financially responsible for all charges whether or not the charges are paid by said insurance, including any insurance deductibles, copayments, co-insurances, and non-covered services. I hereby authorize the above-named assignees and billing representatives to release all information necessary to adjudicate all claims and secure payment for services rendered. Kimberly Bolen McGrew, MA, LPA, LCAS-A and Kimberly Bolen, PLLC are required to provide a clinical diagnosis for insurance reimbursement. Diagnoses are technical terms that describe the nature of your symptoms and reasons for seeking services. My signature below indicates that the above-named assignees have my permission to make a clinical diagnosis or diagnoses. Any diagnoses given will become part of your permanent insurance records. I grant my permission to the above-named assignees and billing representatives to speak with my insurance company and its representatives about issues/questions related to my insurance claims. This may include releasing additional clinical information, such as treatment plans, treatment summaries, or copies of your entire clinical record if requested by your insurance carrier in order to adjudicate claims, review records, or justify medical necessity of services rendered. By signing this agreement, I understand that I am authorizing the above assignees and billing representatives to release any requested information to my insurance carrier if deemed necessary. I understand that it is my responsibility to update Kimberly Bolen, PLLC with any change in insurance information. I agree to no expiration date regarding this permission.

Minor Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

ELECTRONIC COMMUNICATION CONSENT: I understand that all communications with Kimberly Bolen, PLLC, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician. I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cell phones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed. I hereby give my permission to Kimberly Bolen McGrew, MA, LPA, LCAS-A and practitioners/office management and billing staff in association with Kimberly Bolen, PLLC to communicate with me by cellular phone (voice calls, voice message, and text message), email, and fax. I understand that Kimberly Bolen McGrew, MA, LPA, LCAS-A, Kimberly Bolen, PLLC, and associated practitioners will exercise all reasonable precautions, and I will in no way hold Kimberly Bolen McGrew, MA, LPA, LCAS-A, Kimberly Bolen, PLLC, nor associated practitioners/staff, liable for any difficulties resulting to me or any other family member from the communication of confidential information by means of fax, cellular phone, or email. I agree to no expiration date regarding this permission.

Minor Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Appointment Cancellation Policy, Office Procedures, and Financial Policy

The following are conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

MISSED APPOINTMENTS/CANCELLATIONS

MISSED APPOINTMENTS: In fairness to other clients and your therapist, please provide as much notice as possible if you need to cancel or reschedule an appointment, as your appointment time is reserved exclusively for you. Kimberly Bolen McGrew, MA, LPA, LCAS-A does not double book appointments and is rarely able to fill a cancelled session unless she knows ahead of time. **Please be advised that at least 24 hours advance notice and one business day is required to cancel an appointment** (i.e., Appointments scheduled for Monday must be canceled no later than Friday). **You may be charged \$50.00 up to the full session fee for each appointment that was missed or cancelled without 24 hours advance notice**. Reminder calls are a courtesy, and you may be billed for late cancellations and no shows regardless of whether or not you received the reminder message. **Repeated late cancellations and/or no-shows may result in dismissal from treatment, at your therapist's discretion.**

TARDINESS: I understand that sessions will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.

INSURANCE

FOR CLIENTS WITH INSURANCE: All co-payments, co-insurances, and deductibles are due at the time of service. As a courtesy to you, we will bill rendered services to your insurance carrier if we have a current in-network contract with the carrier. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing, all fees are due and become the responsibility of the client. Our office will always strive to help you obtain the maximum possible coverage. It is, however, the client's ultimate responsibility to determine the extent of coverage allowed by the insurance company.

In addition, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Any procedure may be considered not covered under the terms of your agreement with your insurance company. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. In the event of non-payment from your insurance carrier, you are responsible for payment to Kimberly Bolen, PLLC for services rendered, and you will be responsible for handling any disputes with your insurance carrier.

NONCOVERED SERVICES: Any services not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.

FINANCIAL

BASIC POLICY: Payment is due in full at the time service is provided in our office.

RETURNED CHECKS: There will be a fee of \$35.00 charged by this office for each check returned to us by your bank.

OUTSTANDING BALANCES: You are responsible for paying any balances due on your account. Once we receive the Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your

carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Kimberly Bolen, PLLC does not receive payment in full for services rendered, your treatment may be discontinued.

If you are unable to pay your balance in full, a signed payment plan agreement will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuing services. If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services with Kimberly Bolen, PLLC, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with your therapist or the office manager. Any balance not paid in 90 days will be subject to collections.

COLLECTION AGENCY COSTS: In the event that your account is forwarded to a collection agency, you agree to pay an additional fee equal up to 33% of the balance forwarded to the collection agency for balances under \$75 and 40% for balances over \$75 and any additional attorney fees or court costs.

ADDITIONAL SERVICES

In some circumstances, depending on the time involved and the nature of task, you may be charged for additional services such as extended sessions, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment.

PHONE CALLS/EMAILS: Psychotherapy is not provided by phone, unless there are extenuating circumstances that have been discussed in advance with your therapist. Phone calls that are extended and/or constitute therapy will be billed at the rate of \$20/ 15 minutes directly to the client, because insurance does not cover this service. Psychotherapy will also not be provided via email or text communication. If your therapist spends excessive time reading/responding to emails or texts, you will be billed directly at the rate of \$20/ 15 minutes.

TESTING FEES: Charges for psychological testing apply to all tests taken and scored. Sometimes insurance does not reimburse for testing. In this event, you will be responsible for uncovered testing at the self-pay rate.

COLLATERAL APPOINTMENTS: (Appointments about a client without the client present, i.e., parents meet with therapist without child). Some insurance companies do not reimburse for appointments when the client is not present. This could result in the client being billed at the self-pay rate.

FORMS OR LETTERS: Services such as writing letters or completing forms are not covered by insurance. Fees for these services are billed at the rate \$20/ 15 minutes. Please allow at least 7 business days for all requests.

COURT APPEARANCES: Kimberly Bolen McGrew, MA, LPA, LCAS-A is not authorized to testify as an expert witness, due to licensure restrictions. She can only testify to the facts of a case and cannot make recommendations regarding parenting fitness or custody arrangements. Please be advised that her testimony may not be beneficial to your case. If Kimberly Bolen McGrew, MA, LPA, LCAS-A is ordered to make an appearance in court, fees up to \$250 per hour may be collected due to the difficulty of legal involvement. These fees cover expenses, such as review of records, preparation time, phone calls, legal consultation, clinical supervision, documentation, lost wages due to time away from the office, mileage, and other travel expenses. The minimum charge for a court appearance is \$1,500, and a retainer of \$1,500 is due in advance. If the therapist was scheduled to be out of town during testimony, fees will be increased.

ALL CLIENTS/GUARDIANS- PLEASE READ AND SIGN BELOW.

I have read, understood, and agree to be bound by the terms of the appointment cancellation policy, office procedures, and financial policy. I agree to no expiration date regarding this consent.

Minor Client Printed Name: _____

Minor Client Signature: _____ **Date:** _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Kimberly Bolen McGrew, MA, LPA, LCAS-A Clinical Psychologist
Kimberly Bolen, PLLC

CLIENT RIGHTS & CONSENT TO TREATMENT

Thank you for choosing Kimberly Bolen McGrew, MA, LPA, LCAS-A for the opportunity to be your therapist. The therapeutic relationship is one in which each party holds certain rights and responsibilities. The information below is intended to educate you about policies and clarify the nature of the therapeutic relationship.

ETHICAL TREATMENT

You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status. You have the right to be treated in accordance with professional and ethical standards of conduct.

CONFIDENTIALITY AND EXCEPTIONS

You have the right to confidentiality. Kimberly Bolen McGrew, MA, LPA, LCAS-A will not disclose any information without your written consent, including your participation in therapy. Please be advised that state law requires that confidentiality be broken in certain emergency situations, including: 1) to protect you or someone else from imminent danger, 2) to report suspected abuse or neglect of a minor/child or of a person who is elderly or disabled, or 3) if mandated by a court order. If such a situation arises, Kimberly Bolen McGrew, MA, LPA, LCAS-A will make every effort to fully discuss it with you before taking any action. The state law also allows for exchange of clinical information with other medical professionals to assist with coordination of care to provide optimal treatment.

MINORS

If you are under 18 years of age, please be aware that the law provides your parents/guardians the right to review your clinical information. It is Kimberly Bolen McGrew, MA, LPA, LCAS-A's policy to request that parents respect their children's confidentiality; otherwise, the integrity of the therapeutic relationship and effectiveness may be adversely impacted. If they agree, parents/guardians will only be provided with general information about your therapy, unless your therapist feels there is a risk that you are engaging in dangerous behaviors or may seriously harm yourself or someone else. In this case, your parents will be notified of the concern(s). Before disclosing information to parents, Kimberly Bolen McGrew, MA, LPA, LCAS-A will make every effort to discuss the matter with you, and if possible, address any objections you may have.

PROFESSIONAL RECORDS

The laws and standards of Kimberly Bolen McGrew, MA, LPA, LCAS-A's profession require that treatment records be maintained. Clinical records will be maintained in a secure, locked environment. Your records are kept on file for 7 years from the date of your first appointment and destroyed at the end of the 7-year period. Your file contains a copy of this informed consent, intake paperwork, and all materials that pertain to you. This file is confidential with the exceptions noted in the **Confidentiality and Exceptions** section.

SUPERVISION REQUIREMENTS AND CONSULTATION

I understand that Kimberly Bolen McGrew, MA, LPA, LCAS-A may consult and share clinical information with her supervisor, Dr. Sally MacKain, and/or clinical board in order to provide legal and ethical treatment.

She may also do so to meet the requirements set forth for their licensure or certification. I understand and give my consent for Kimberly Bolen McGrew, MA, LPA, LCAS-A to consult with other licensed professionals in the therapeutic (e.g., psychologists, counselors, social workers, etc.) or medical community in order to receive peer supervision and provide me with the most ethical and effective treatment possible.

THERAPY PROCESS

Your first therapy appointment will be an intake assessment, which typically lasts between 60-90 minutes. Kimberly Bolen McGrew, MA, LPA, LCAS-A strives to provide a relaxed atmosphere where you can openly discuss your concerns. This initial session is designed to thoroughly evaluate your history, emotional and behavioral concerns, and determine treatment goals together. The evaluation may continue during the first few subsequent sessions.

Follow-up psychotherapy sessions last approximately 50 minutes, with a few minutes reserved at the end of each session to schedule appointments and collect your copayment, if applicable. Psychotherapy is intended to result in measurable outcomes to reach treatment goals and relies on evidence-based treatments, such as cognitive behavioral therapy, dialectical behavior therapy, and acceptance and commitment therapy. Kimberly Bolen McGrew, MA, LPA, LCAS-A is committed to approaching therapy with empathy and compassion, while also providing direct feedback to teach problem-solving strategies and coping skills. Your progress towards treatment goals will be assessed periodically. Psychotherapy may be continued in order to improve a psychological condition, prevent the onset or worsening of a condition, assist you in achieving or maintaining maximum functional capacity, alleviate or mitigate the severity of clinical/ behavioral symptoms, and/or help you perform activities of daily living.

MULTIPLE RELATIONSHIPS

Kimberly Bolen McGrew, MA, LPA, LCAS-A's code of ethics dictates that she will not enter into a multiple/dual relationship with a client, such as engaging in a friendship outside the therapy setting or entering into another type of professional relationship with a client (e.g., Kimberly Bolen McGrew, MA, LPA, LCAS-A would not hire a client as her real estate broker or accountant). This ensures that your therapist can maintain objectivity and provide you with optimal treatment.

TREATMENT OUTCOMES

The therapeutic relationship is collaborative, in which you will work together actively with your therapist to reach treatment goals. It is recommended that you participate actively in treatment and openly discuss your concerns. Treatment recommendations will likely be made, but ultimately you have the autonomy to make your own decisions. Participation in psychotherapy can have benefits and risks. Successful treatment will require the investment of your time and energy. Since psychotherapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, anxiety, guilt, or frustration, etc. On the other hand, psychotherapy has also been shown to have benefits for people and often leads to significant reductions in feelings of emotional distress, solutions to specific problems, more adaptive coping strategies, and improved relationships. Please be advised that there is no guarantee that any particular outcome will result from treatment.

TERMINATION

Your decision to enter therapy is voluntary, and you have the right to discontinue therapy at any time. Termination of the therapeutic relationship is a natural occurrence when you have met your treatment goals. However, please confer with your therapist rather than ending treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals. Please allow a minimum of 7 business days for a treatment summary. A meeting with your therapist is recommended to review the content of your treatment summary. In addition, the therapeutic relationship may be terminated if,

in your therapist's professional opinion, it is in your best interests to refer you to another therapist or if continued treatment is deemed to be no longer beneficial or may be harmful to you at the current level of care (e.g., level of functioning necessitates a higher level of care or in the case of non-compliance with treatment recommendations regarding your safety or well-being). Termination will occur automatically 30 days from the date of your last session, unless you have an agreement with your therapist for your case to remain open.

EMERGENCIES

In case of emergency, please dial 911 or go to your nearest emergency room. You may also call the local Mobile Crisis Unit at 1-844-709-4097 for 24-hour access to care and crisis services or Trillium Health Resources 24-hour information line at 1-877-685-2415 for assistance with screening, triage, and referrals. Kimberly Bolen McGrew, MA, LPA, LCAS-A operates a solo outpatient private practice where clients are assumed to be self-responsible, autonomous, functioning individuals who are not in need of day-to-day supervision. She cannot, and does not, assume responsibility for client's daily functioning in the way institutions and facilities can. You may also call your therapist during business hours or for after-hours emergencies at (910) 512-2890. This number should only be used for scheduling/rescheduling and for **true emergencies only**, such as assistance with being hospitalized, and you agree to accept the help that is given. During business hours, Kimberly Bolen McGrew, MA, LPA, LCAS-A is usually in session most of the day with other clients and will do her best to return routine phone calls by the end of the next business day. Your therapist may not be available at all times, so please use the other crisis numbers listed in the event of an emergency. If your therapist will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

ALL CLIENTS/GUARDIANS- PLEASE READ AND SIGN BELOW.

I HAVE READ AND UNDERSTAND THE HIPAA PRIVACY POLICIES, THIS STATEMENT IN ITS ENTIRETY, MY CLIENT RIGHTS, AND THE LIMITS OF CONFIDENTIALITY. I HAVE HAD SUFFICIENT TIME TO CONSIDER IT CAREFULLY AND WILL ADDRESS ANY CONCERNS WITH MY THERAPIST. I UNDERSTAND MY RIGHTS AND RESPONSIBILITIES AS A CLIENT AND MY THERAPIST'S RESPONSIBILITIES TO ME. MY SIGNATURE BELOW CONSTITUTES MY CONSENT TO TREATMENT WITH KIMBERLY BOLEN MCGREW, MA, LPA, LCAS-A AND I AGREE TO NO EXPIRATION DATE REGARDING MY CONSENT TO TREATMENT.

Minor Client Printed Name: _____

Minor Client Signature: _____ **Date:** _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

I have addressed the client's/parent's/guardian's concerns and /or questions. The client appears fully competent to give informed content.

Kimberly Bolen McGrew, MA, LPA, LCAS-A

Date

Professional Disclosure Statement
Kimberly Bolen McGrew, MA, LPA, LCAS-A
Kimberly Bolen, PLLC

Kimberly Bolen McGrew is a licensed as a Psychological Associate (#3605) by the North Carolina Psychology Board and a Clinical Addiction Specialist-Associate (#23563) by the North Carolina Substance Abuse Professional Practice Board. She is also certified as a Health Services Provider-Psychological Associate. She obtained her master's degree in Clinical Psychology with an emphasis on substance abuse treatment from the University of North Carolina at Wilmington in 2008. She receives clinical supervision from Dr. Sally MacKain, a Licensed Psychologist (#1605) to ensure the utmost quality of care.

Ms. McGrew has gained clinical experience through working in an outpatient psychotherapy setting since 2008. Prior to licensure, she completed a practicum and internship at an outpatient mental health center offering individual and group therapy and received additional clinical training through community outreach programs. Ms. McGrew has experience treating individuals with various emotional and behavioral concerns, including depression, mood disorders, anxiety disorders, personality disorders, substance abuse and dependence, PTSD, dual diagnosis and relationship issues. She also completed crisis intervention training to assist trauma survivors.

Ms. McGrew's treatment approach includes the use of Cognitive Behavioral Therapy (CBT), which helps individuals develop more effective thinking patterns and learn adaptive coping strategies. She also has specialized training in Acceptance and Commitment Therapy (ACT), which supports values identification and achievement of goals despite difficult circumstances, and the Gottman Method, which provides research-based guidelines for improving relationships and marriages. Other specialized training includes Dialectical Behavior Therapy (DBT), which is a beneficial treatment for people who have difficulty regulating emotions, tolerating distressing situations, and dealing with interpersonal problems effectively. Other treatment modalities may be implemented when appropriate.

Ms. McGrew will file in-network insurance claims as a courtesy. Payments by clients may be made in the form of cash, check, or credit card and are due at the time of service. Health insurance companies routinely require that a diagnosis be given in order to provide reimbursement for services rendered. All diagnoses are confidential and will only be shared with third party payers (insurance companies) when required, unless otherwise directed by the court of law. All information disclosed within a therapy session is also confidential and may not be shared with anyone with the exception of the following:

- Harm to Self or Others
- Suspicion of Child or Elder Abuse/Neglect
- Court Order
- Supervision Requirements to Provide Ethical Treatment and Maintain Licensure

If at any time, for any reason, you have questions, comments, or concerns, please discuss them with your therapist. If you need further assistance regarding a complaint about this clinician's ethical conduct, you may register a complaint with the North Carolina Psychology Board as listed below.

North Carolina Psychology Board, 895 State Farm Road, Suite 101, Boone, NC 28607

Minor Client Signature	Date	Parent/Guardian Signature	Date
Kimberly Bolen McGrew, MA, LPA, LCAS-A	Date		

Kimberly Bolen McGrew, MA, LPA, LCAS-A *Clinical Psychologist*
Kimberly Bolen, PLLC

This form must be completed for all clients who are under the age of 18. A legal guardian must complete this form to designate the following.

ACKNOWLEDGEMENT OF GUARDIAN/CUSTODIAN

I, (print name) _____, certify that I am the legal guardian/
custodian of (print minor child/adolescent client's name): _____.

Legal Guardian Signature

Date

Kimberly Bolen McGrew, MA, LPA, LCAS-A *Clinical Psychologist* Kimberly Bolen, PLLC

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

It is important for your therapist and doctors to have access to relevant medical information to ensure that you receive the best care possible. The purpose of sending/requesting your health information to/from your doctor is to assist in identifying any follow-up medical care that may be needed. If you would like for your therapist to communicate with and send/receive your health information to/from your primary physician, psychiatrist, previous mental health therapist, or another medical provider/person/organization, please sign the release of information below. Kimberly Bolen McGrew, MA, LPA, LCAS-A will only send information that pertains to your care.

Client Name: _____ **DOB:** _____

MUTUAL EXCHANGE OF INFORMATION

Kimberly Bolen McGrew, MA, LPA, LCAS-A, Kimberly Bolen, PLLC
1213 Culbreth Drive, Suite 125
Wilmington, NC 28405
Phone: (910) 512-2890 Fax: (910) 821-8447

AND

Please list your doctor/clinician's name (or the person you are authorizing release of information to) and the individual's contact information below:

Mr./Ms./Dr. _____ Facility (if applicable) _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Please Initial the information to which this authorization applies: (the first item covers all clinical information)

- ☐ Full Clinical Health Information Record **Including** Substance Abuse Information if Applicable
☐ Full Clinical Health Information Record **Excluding** Substance Abuse Information
☐ Psychological Evaluation
☐ Verbal Communication
☐ Other (please list specific types of information): _____
☐ Medical Records
☐ School Records

NOTICE OF RIGHTS AND OTHER INFORMATION

Complete your acknowledgement that you understand that:

- You have the right to review the information that is being used or disclosed.
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws.
- You have a right to revoke this authorization at any time.
- You have a right to receive a copy of this signed authorization.

Permission/authorization to release this information expires one year from the date below.

Minor Client Signature: _____ **Date:** _____ **Time:** _____

Parent/Guardian Signature: _____ **Date:** _____ **Time:** _____