**CLARITY COUNSELING SOLUTIONS, LLC**

**CLIENT INFORMATION** Today’s Date **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Please circle preferred number to contact***

Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event that I need to call you on the phone:

Should I leave a message on voicemail? Y / N

Should I leave a message with another person? Y / N If so, whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Sex \_\_\_\_\_\_

Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to my office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary Care Physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What lead you to seek counseling?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What are your goals for counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any legal concerns? Yes No Please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had suicidal thoughts or attempted suicide? Yes No Please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had homicidal thoughts or attempted homicide? Yes No Please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen another therapist or psychiatrist? Yes No

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications? Yes No

Names and dosages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any issues with substance abuse? Yes No Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent**

\_\_\_\_\_\_\_\_ I give Clarity Counseling Solutions, LLC permission to discuss my protected health information, with the following:

Name Relationship Phone Number

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

This consent will expire one year from today’s date, unless I otherwise specify any expiration date here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ I wish to keep my protected health information private. I reserve the right to change this in the future. I understand that there are exceptions (see practices and procedures.)

**INSURANCE INFORMATION:** I will file with your insurance company for you; however, you are responsible at the time of service for any deductibles, co-pays, and services that your insurance does not cover.

***Primary Insurance Company*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*(If not self)**

Policy Holder’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders’ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Secondary Insurance Company***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders’ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CREDIT CARD AUTHORIZATION FORM**

I authorize Clarity Counseling Solutions, LLC to keep my signature on file and to charge fees, or partial fees, to my Credit Card account for services provided to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Print Patient or Client Name)

The fee is $50 for missed appointments or appointments not canceled within 24 hours. This is non-payable by insurance companies.

I agree that:

this authorization is valid until canceled by me in writing,

charges for missed appointments or cancellations without 24 hour notice will be posted to my credit card account within a week of each service date.

Record requests sent via postal mail are $10. Returned check fees are $25.

***I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Clarity Counseling Solutions, LLC.***

Cardholder Name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address (where your statements are mailed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Type (circle one): Visa MC Amex Discover Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

Acct # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_ CCV:\_\_\_\_\_\_\_\_

Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Brandy Sheth, LPC, MS

**Clarity Counseling Solutions, LLC**

3501 Severn Ave. Ste H

Metairie, La. 70002

(504)201-5962

Declaration of Practices and Procedures

**Qualifications:** I received a MS degree in Counseling from Loyola University New Orleans. I am a licensed professional counselor (LPC) (#3138) registered with the LPC Board of Examiners, which is located at 8631 Summa Avenue, Baton Rouge, La. 70809 (phone (225)765-2515.)

**Counseling Relationship:** The counseling relationship will focus on exploring the issues that led you to seek counseling. Goals will be developed and plans to implement these goals will be stressed. Common goals to counseling relationships include building a greater sense of personal independence and fostering personal growth.

**Areas of Expertise:** I have worked with a wide range of populations, including school counseling, the chronically mentally ill, and addictions. I have extensive training in mood and thought disorders, obsessive compulsive disorder, stress management, anger management, addictions, and relationship issues.

**Fee Scales:** Fees vary by service type and are due at the time of service. Fees are also charged for returned checks, court appearances, depositions, and travel/preparation time. Clients will be charged for appointments that are missed or cancelled without 24 hour notice. Insurance companies do not reimburse for missed appointments. Payment is accepted from certain insurance companies. Some insurance companies require prior authorization for sessions. In order to do so, your clinical records will need to be submitted.

**Code of Conduct:** As a LPC, I am required by law to adhere to the Code of Conduct for practice that has been adopted by my licensing board. A copy of this Code of Conduct is available to you upon request.

**Services Offered:** I approach counseling from a multidimensional perspective, stressing both existential and cognitive behavioral therapy. The premise of existential therapy focuses on finding meaning and purpose in one’s life. The premise of cognitive behavioral therapy explores how a person’s way of thinking affects his or her feelings and behaviors. In the counseling relationship, we will examine unhealthy thinking patterns and work to correct these patterns.

**Confidentiality:** What is talked about between you and I will remain between us except for these instances: 1. the client expresses intent to harm another person or him/herself, 2. there is abuse or neglect of a minor, elderly or disabled person, 3. I am ordered by the court to release information, 4. the client has given written permission for information to be released to another mental health, medical, legal professional, or others, 5. I am required otherwise by law to release information. 6. Information may be released to a third party payor to collect payment.

Stating from HIPPA regulations, voicemail is the only mode of communication that is confidential. If you communicate with me by other modes of communication, email, text, etc. please be advised that the confidentiality of that communication cannot be guaranteed.

Please be advised that I regularly consult with other licensed colleagues. However, if I consult on your case, all identifying information will be excluded from the consultation.

\*\* Any material obtained from a minor client may be shared with that client’s parents or guardian.

**Emergency Situations:** If an emergency situation should arise, you may seek help through hospital emergency rooms or by calling 911.

**Client responsibilities:** You and I are in this process together, and I need your full cooperation. It is your responsibility to actively participate in session, arrive on time for appointments, do homework when assigned, inform me if you are seeing another mental health professional, inform me of any medications you are taking, and have a physical within the last year, if not already done. In the event that one of us feels he/she cannot work with the other, I will provide a list of referrals that may be able to assist you better. You are responsible for contacting the referrals.

**Potential Counseling Risks:** There are no guaranteed outcomes in counseling. I cannot guarantee results nor can I guarantee that you will feel better. Furthermore, the client may actually feel worse during the course of the counseling relationship, compared to before counseling. This is due to the fact that some issues may surface that were hidden and unknown before. If such problems arise, please feel free to share these new concerns with me.

By signing below, you are stating that you have read the disclosure statement and understand it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor’s signature Date

For minor clients: I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission for Brandy Sheth/Clarity Counseling Solutions, LLC to conduct counseling with my \_\_\_\_\_\_\_\_\_\_\_\_\_, name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Parent/Guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA REQUIREMENTS:**

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS DOCUMENT**

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT

YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS

INFORMATION. PLEASE REVIEW IT CAREFULLY.

The law protects the privacy of communications between a client and a counselor. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA (Health Insurance Portability and Accountability Act of1996). There are other situations that require only that you provide written advanced consent. Your signature on the Informed Consent Agreement provides consent for those activities as follows. Use and disclosure of protected health information for the purposes of providing services: Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes as follows.

**TREATMENT:**

I may use and disclose health information to

1. Provide, manage, or coordinate care with your physician or other healthcare provider who is also treating you;

2. Ensure that I am providing the highest quality counseling, I may consult with other mental health providers. During such consultations, I make every effort to avoid revealing the identity of my client. The other professionals are legally bound to keep the information confidential. I will note all consultations in your records.

**COLLECTING PAYMENT:**

 If you would like to attempt to seek reimbursement for counseling from your health insurance provider, I will disclose information to your insurance provider at your request. If you have not paid for services at the time of your appointment as required, I may be forced to send you a bill which may include information that identifies the client as well as other healthcare information.

**HEALTHCARE OPERATIONS:** I may have to disclose health information for both clinical and administrative purposes, such as review of treatment procedures, review of business activities, certification, compliance, and licensing activities.

**OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT:**

1. I am mandated to report the following to the appropriate authorities:

a. If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

b. If I have reason to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon them, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

c. If I determine that a client represents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim and/or contacting the police, and/or seeking hospitalization for the client. If such a situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary;

d. If I determine that you are a serious threat to yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection.

e. If ordered by a court of law. If you are involved in a court proceeding and a request is made for information regarding my professional services, such information is protected by the counselor-client privilege law, unless I am ordered to release it by the court. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

f. If a government agency is requesting information for health oversight activities, I may be required to provide it for them.

g. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding the client in order to defend myself.

h. If a client files a workers’ compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

**CLIENTS’ RIGHTS**

1. You have the right to request where I contact you: home, work, cell phone, e mail, or some other means of your choice.

2. You have the right, by written authorization, to release your medical records to others. You also have the right to revoke that release in writing. Revocation is not valid to the extent that I have already acted in reliance on your previous authorization.

3. You have the right to make a written request to inspect and copy your records. You will be charged $0.10 per page for copying in addition to any mailing costs. I may, under some circumstances, deny this request.

4. You have the right to make a written request that I amend your records. I will have at least 30 days to decide whether to amend your records as you have requested and in some instances may deny your request. If your request is denied, you have the right to file a disagreement statement. Your disagreement statement and my response will be filed in the record.

5. You have the right to make a written request for an accounting of disclosures made of your health information with the following exceptions: disclosure for treatment, payment, or healthcare operations; disclosures pursuant to a signed release; disclosures made to the client; disclosures for national security or law enforcement purposes.

6. You have the right to make a written request to restrict uses and disclosures of your healthcare information; however, I am not obligated to agree to your request. If I do not agree to your request, you have the right to complain: first to me and secondly to the U.S. Department of Health and Human Services. I will not retaliate against you for such complaints.

7. You have the right to receive changes in policies.

If you have any questions or concerns about the foregoing, please do not hesitate to ask me, and I will make every attempt to answer them.

**HIPAA REQUIREMENTS:**

**NOTICE OF PRIVACY PRACTICES AND CLIENTS RIGHTS DOCUMENT**

I acknowledge by signing below that I was given a copy of the HIPAA REQUIREMENTS: NOTICE OF PRIVACY PRACTICES AND CLIENTS RIGHTS DOCUMENT by Clarity Counseling Solutions, LLC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date