Kimberly Bolen McGrew, MA, LPA *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? ☐ Google Ad ☐ Google Search

☐ Psychology Today Profile ☐Network Therapy Profile ☐Website

☐ Referred by _____ ☐ Other: _____

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). If you choose not to complete this section, should an emergency arise, I will contact 911.

1213 Culbreth Drive • Suite 125 • Wilmington, NC 28405
Phone: (910) 512-2890 │ Fax: (910) 821-8447 │

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 coordinate care with your primary physician?

Yes / No

Primary Physician Address: _____

_____

Primary Physician Phone Number: (_____) _____

Continued on Next Page

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):

___Romantic Relationships
___Family Relationships
___Peer Relationships
___Divorce/Separation
___Stress
___Depression
___Loneliness/Social Isolation
___Lack of Motivation
___ Feelings of Guilt
___Feelings of Hopelessness
___ Sleep Problems (too much/too little)
___Nightmares
___Feeling Overwhelmed
___Anxiety
___Fears/Phobia
___Doing Things Over and Over
___Unwanted Habits
___Panic
___Flashbacks
___Legal Problems
___Financial Problems
___Career Planning
___Unemployment
___Academic Performance
___Learning Disabilities
___Attention Problems
___Confusion

___Self-Confidence/Self-Esteem
___Body Image
___Eating Disorder/Eating Issues
___Drug/Alcohol Abuse
___Physical Abuse
___Sexual Abuse/Molestation
___Sexual Assault
___Other Traumatic Event
___High Energy
___Racing Thoughts
___ Fatigue
___Memory Difficulties
___ Problems at Work/School
___Anger Management
___Homicidal Feelings
___Suicidal Feelings
___Self-Harm
___Hearing Voices
___Thoughts that Scare Me
___Racial/Cultural Issues
___Gender or Sexual Identity Issues
___Grief/Loss
___Physical Health Concerns
___Pregnancy (past, present)
___Spirituality Concerns
___Trouble Making Decisions
___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.
___ Quite well, no important complaints.
___ Fairly well, but have ups and downs.
___ So-so, can keep going with effort.
___ Quite poorly, can barely manage.
___ 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/or therapy benefits, to include major medical benefits to which I am entitled, Private insurance, and any other health plans to Kimberly Bolen McGrew, MA, LPA 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 I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorize said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered. My signature below indicates that the above named assignee and billing representatives have my permission to make a clinical diagnosis and to speak with my insurance company and its representatives about issues/questions related to my insurance claims. I agree to no expiration date regarding this permission.

Client/Guardian Signature: _____Date:_____

ELECTRONIC COMMUNICATION CONSENT: I hereby give my permission to Kimberly Bolen McGrew, MA, LPA 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, Kimberly Bolen, PLLC, and associated practitioners will exercise all reasonable precautions, and I will in no way hold Kimberly Bolen McGrew, MA, LPA, 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.

Client/Guardian Signature: _____Date:_____

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Office Procedures, Financial Policy, and Appointment Cancellation Policy

The following are our 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. **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.**

INSURANCE

FOR CLIENTS WITH INSURANCE: All co-payments and deductibles are due at the time of services. We will bill insurance carriers on your behalf if we have a current 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, our fees are due and payable from you. 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, preauthorization of a procedure is not a guarantee for payment. Any procedure may be considered not covered under the terms of your agreement with your insurance company. Your insurance carrier will make a determination of payment once the claim is received and reviewed. If after the claim is reviewed and it is determined by your insurance company that the procedure is **not** covered you will be financially responsible to Kimberly Bolen, PLLC for the charges and will be billed for those services not covered by your insurance company.

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.

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: Typically there is no charge for phone calls. However, 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.

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.

ALL CLIENTS- PLEASE READ AND SIGN BELOW.

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

Client/Guardian Printed Name: _____ Relationship to Client: _____

Client/Guardian Signature: _____ Date: _____

Continued on Next Page

Kimberly Bolen McGrew, MA, LPA *Clinical Psychologist*
Kimberly Bolen, PLLC

CLIENT RIGHTS & CONSENT TO 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.
- You have the right to confidentiality. I will not disclose any information without your written consent. Clinical records will be maintained in a secure, locked environment. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order. The state law also allows for exchange of clinical information with other medical professionals to assist with coordination of care to provide optimal care.
- You have the right to discontinue therapy at any time. 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.
- In fairness to other clients, 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.
- I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- I understand that there is no guarantee that any particular outcome will result from treatment.
- I understand that my therapist 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 my therapist 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.
- For after-hours emergencies, please dial 911 or go to your nearest emergency room. You may also call Trillium Health Resources emergency hotline at 1-877-685-2415 or our local Mobile Crisis Unit at 1-844-709-4097 for 24 hour access to care and crisis services. You may also reach your therapist after hours 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. Your therapist may not be available at all times, so please use the other crisis numbers listed.

I HAVE READ AND UNDERSTAND THE HIPPA PRIVACY GUIDELINES, THE CLIENT BILL OF RIGHTS, AND THE LIMITS OF CONFIDENTIALITY AND WILL ADDRESS ANY CONCERNS WITH MY THERAPIST. MY SIGNATURE BELOW CONSTITUES MY CONSENT TO TREATMENT WITH KIMBERLY BOLEN MCGREW, MA, LPA, AND I AGREE TO NO EXPIRATION DATE REGARDING MY CONSENT TO TREATMENT.

Client/Guardian Printed Name_____ **Date**_____
Client/Guardian Signature_____

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 **Date**

1213 Culbreth Drive • Suite 125 • Wilmington, NC 28405
Phone: (910) 512-2890 | Fax: (910) 821-8447 |

Professional Disclosure Statement
Kimberly Bolen McGrew, MA, LPA
Kimberly Bolen, PLLC

Kimberly Bolen McGrew is a Licensed Psychological Associate (#3605) and 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 primarily utilizes a cognitive-behavioral theoretical orientation, which focuses on modifying maladaptive thoughts, feelings and behaviors. She also has specialized training in dialectical behavior therapy, which teaches adaptive coping skills to help individuals tolerate distress, regulate emotions, and handle 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. Payments are due at the time of service. Within the context of therapy sessions, the client may be given a diagnosis. 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

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

_____	_____	_____	_____
Client/Guardian Signature	Date	Kimberly Bolen McGrew, MA, LPA	Date

Kimberly Bolen McGrew, MA, LPA *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**

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Phone: (910) 512-2890 | Fax: (910) 821-8447 |

Kimberly Bolen McGrew, MA, LPA *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. We will only send information that pertains to your care.

Client Name: _____ DOB: _____

MUTUAL EXCHANGE OF INFORMATION

Kimberly Bolen McGrew, MA, LPA, 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 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.

Client/Guardian Signature: _____ Date: _____ Time: _____

