Reproductive Journey
Counseling & Support Services Application
Service Provider: Susannah Baldwin, MEd, LPC

[Please be as complete as possible with this information as it may help us serve you better.]

Client Name:_____

Address:_____
[Please give both "street" & "mailing" addresses, if different.]

_____ _____ _____
City **State** **Zip Code**

Telephone Numbers:_____ _____ _____
Home **Work [Extension]** **Other [Specify]**

E-mail Address:_____
[Please indicate whether the email you receive at this site is secured (S) or unsecured (U).]

Preferred method of contact: ___Home ___Mobile ___Work ___Email ___Other _____

Birthdate:_____ **Social Security #:**_____

Sex:___**Male** ___**Female** **Marital Status:**_____

Education: 0 PS K 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19+
[Circle highest grade or year completed]

Degrees(s):_____ **Current School [if enrolled]:**_____

Employer [if any]:_____

Primary Care Physician:_____

Current Health Issues [if any]:_____

Current Household Members: [For all persons in home, list name, age, & relationship to client, if any]:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Emergency Contact information:

Name: _____ Relation to client: _____

Phone: _____ Alt. contact _____

Prior Mental Health Services Experience(s):_____ Yes; _____No. If "Yes," please give a brief description of the reason(s) service was sought, when/where service was received, who provided the service, and whether it was helpful or not helpful in reaching your goal(s).

_____

_____

_____

List all currently prescribed/over-the-counter medications: [Please give the name, amount (mg), dosage frequency, length of time taken, and prescribing physician for each.**]**

_____

_____

_____

_____

Who referred you to this office? [Please specify**]: _____**

Please describe the concern(s) that brings you here. _____

_____

_____

_____

What has prompted you to seek assistance <u>now</u>? _____

_____

What change(s) do you want to see as a result of this service? _____

_____

_____

_____ _____

Date **Signature of Client**

_____ _____

Date **Signature of Additional Client [e.g. Partner if entering Couple's Treatment]**

Reproductive Journey Counseling & Support
Disclosure Statement for Susannah Baldwin, MEd, LPC

Thank you for choosing Susannah Baldwin, MEd, LPC. Today's appointment will take approximately 45-50 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies and your rights. If you have questions or concerns, please ask and we will try our best to give you all the information you need.

Identifying Information:
Name: Mary Susannah Baldwin
Title: Adult and Couples Counselor
Highest Relevant Degree: Masters of Education (Clinical Mental Health Counseling) 2011, Clemson University
Business Address & Phone: Bay Laurel Center for Psychotherapy
110 Manly St. Greenville, SC 29601 (864) 298-8026
Relevant Credentials: Licensed Professional Counselor, SC #6138

Appointments: The office staff of Bay Laurel will be your contact for making appointments, leaving messages as well as for billing questions. The office staff is bound by confidentiality for the protection of your private health care information.

Number of years of counseling experience and clientele served: I have 8 years of counseling and counseling-related experience addressing a variety of emotional concerns. I worked for 1 year as a counselor intern working with children in either DJJ or DSS. I worked for 2 years as a counselor at a domestic violence agency. In that role I provide individual and group counseling from a cognitive-behavioral and client centered approach. Additionally, I worked at Blessed Births as a mental wellness counselor for 1 ½ years counseling individuals and couples addressing emotional issues, parenting and relationship satisfaction. Four years ago, I started my private practice specializing in issues surrounding the reproductive journey.

Description of services offered: I will be offering professional counseling services to individuals and couples who are dealing with any number of mental health and wellness concerns including but not limited to: anxiety, depression, relationship concerns, parenting issues, self awareness and personal growth, behavioral concerns, life transitions, and grief and loss. I conduct these sessions from a cognitive behavioral, client centered and interpersonal approach.

Confidentiality: The information you share in therapy is generally considered confidential by SC statute law and federal regulations. Your therapy file can be released in SC through a court order (signed by a judge), but is considered privileged in the federal court system.

Exceptions to confidentiality (which are mandated by state and federal regulations) include the following:

- You are threatening to hurt yourself
- You are threatening to hurt some one else
- A child has been or is being abused or neglected
- A vulnerable adults has been or is being abused or neglected

If you wish that your protected information (defined by HIPAA) be released to someone such as a health care provider, attorney or other counselor you must sign a specific Release of Information form.

Complaint procedure: Please know I am open to discussing any concerns you may have about your counseling process or experience. However, should any client wish to register a complaint regarding my services with the South Carolina Department of Labor, Licensing, and Regulation, they may do so by writing to the following address: SC LLR 110 Centerview Drive Columbia, SC 29210, or by calling the following number: 803-896-4300.

Financial Policy: *See the Fee Schedule form for specific amounts.*
It is customary to pay for professional services at the time of service. If I have a managed care contract with your insurance company, you will be required to pay the contracted fee or co-payment for your therapy. If you choose the private pay option (meaning not filing with your insurance agency) I am accountable only to you, protecting your privacy and eliminating the need for a "mental disorder" label or diagnosis.

You may pay cash, check or credit card. Checks returned by your bank are subject to a $35.00 processing charge. Your appointment time represents time that has been designated solely for you. If you are not able to keep a scheduled appointment and do not give at least 24 hour notice or fail to show up for your scheduled appointment, you are subject to being charged for the missed appointment.

By signing below, I agree that I have read the LPC Disclosure Statement, have had an opportunity to ask questions and seek clarification, and understand all of the information presented.

_____ _____

Signature of Client Date

_____ _____

Signature of Additional Client Date

Fee Schedule & Billing Policy
Susannah Baldwin, MEd, LPC

Service Description	Length of Time		Charge
Initial consultation	50 minutes		$ 52.50
Individual Psychotherapy	50 minutes		$105.00
Home visit / travel within 10 miles of office		additional	$ 40.00
Couples/Marital Therapy	50 minutes		$105.00
Late notice missed appointment			$ 60.00
Crisis Psychotherapy	50 minutes		$135.00

This type of session refers to an on-call, unscheduled face-to-face session that must be added onto the therapist's regular hours in order to address a crisis.

Consultations	50 minutes	$135.00

Consultations include, but are not limited to, presentations for companies or organizations, attorney briefings/discussions, legal depositions and court appearances (including those required by subpoena), and the time required for preparation and travel.

Clinical Consultations by		
Telephone or Internet	1-15 minutes	$50.00
	16-30 minutes	$85.00
	31-50 minutes	$135.00

*These consultations, whether emergency or non-emergency based, are viewed as an extension of the office therapeutic experience. Availability for this **on call** purpose has been established on a 24-hour/7 day per week basis. We reserve the right to charge for this time in keeping with our billing policy. Be aware, most insurance companies do not reimburse for phone or Internet consults.*

Note: Clients who are receiving services under an insurance plan may have fees that have been negotiated by that plan's contractors. If so, your fees may be different. Please check with our staff or your therapist if you have any concerns about your fees.

Reminder: If you are unable to keep your appointment, you must give us at least 24 hours notice or you may be charged the designated fee.

I have read and understand the above Fee Schedule and Billing Policy.

_____

Signature of Client or Legal Representative

_____

Signature of Additional Client [e.g.partner, if entering couple's treatment]

Reproductive Journey Counseling & Support

Waiver Regarding Missed Appointments

Service provider: Susannah Baldwin, MEd, LPC

We understand that unforeseeable things happen to prevent attendance at a scheduled appointment. Therefore, clients are granted one (1) late-notice missed appointment (less than twenty-four (24) hours) every 6 months at no charge.

I, _____, understand this policy and agree to be financially responsible for any missed appointments for which I have not given the agreed upon advanced, twenty-four (24) hours notice of cancellation at a rate commensurate ($60.00) with the time allotted to me for the appointed service.

_____ _____

Clients Signature Date

_____ _____

Additional Client's Signature Date

BAY LAUREL CENTER NOTICE OF PRIVACY PRACTICES

This *Notice* describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this *Notice* about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI" under the Health Insurance Portability and Accountability Act of 1996, "HIPAA"). We will follow the privacy practices that are described in this *Notice*.

SECTION I - USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures ***WITHOUT*** Your Written Authorization
   - Uses or disclosures required by law, such as mandatory reporting of child abuse or neglect.
   - Uses or disclosures required by Court Order.
   - Uses or disclosures necessary to prevent or lessen a serious or imminent threat to the safety of yourself or others (duty to warn). If the information is disclosed to prevent or lessen a serious threat, it will be disclosed to the person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
   - Uses or disclosures for judicial or administrative hearings, such as a case where you are claiming malpractice or breach of ethics.
   - Uses and disclosures for health and oversight activities, such as correcting records or correcting records already disclosed.

B. Uses and Disclosures ***REQUIRING*** Your Written Authorization
   - Psychotherapy notes recorded by the clinician documenting the contents of a therapy session as well as your medical record will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.
   - Uses and disclosures other than those described in Section 1A above will only be made with your written authorization. You may revoke any such authorization at any time.

SECTION II – YOUR INDIVIDUAL RIGHTS

A. Right To Inspect and Copy: You may request access to your medical record in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a reasonable fee for the costs of copying and sending you the requested records. Psychotherapy notes are afforded special privacy protection under the regulations and are excluded from this right.

B. Right To Alternative Communication: You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right To Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing. We are not required to agree to any such restriction you may request.

D. Right To Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by us after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures authorized by you, and is subject to restrictions and limitations.

E. Right To Request Amendment: You have the right to request that we amend your health information. Your request must be in writing. We may deny your request under certain circumstances.

F. Right To Obtain Notice: You have the right to request a paper copy of this *Notice*.

G. Questions and Complaints: If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, please let your particular therapist know. If you are concerned that we

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have violated your privacy rights, you may also file a complaint with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or ourselves.

III. EFFECTIVE DATE AND CHANGES TO THIS *NOTICE*

A. Effective Date: This *Notice* is effective April 14, 2003.

B. Changes To This *Notice*: We may change the terms of this *Notice* at any time. If we change this *Notice*, we may make the new *Notice* terms effective for all PHI we maintain, including any information created or received prior to issuing the new *Notice*. If we change this *Notice*, we will post the revised *Notice* in the waiting area of our office. You may also obtain any revised *Notice* by request.

❖❖❖ALL THERAPISTS AT BAY LAUREL CENTER, INC. ARE IN INDEPENDENT, SOLO PRIVATE PRACTICE❖❖❖

I acknowledge that I have been given this document - BLC ***Notice of Privacy Practice*** - and that I have read this document. My signature below confirms that I understand and accept all the information contained in the ***Notice of Privacy Practices***.

_____ _____

Signature of Client Date

If this acknowledgement is signed by a personal representative on behalf of the client, please complete the following:

Personal Representative's Name: _____

Please Print Clearly

Relationship To Client: _____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of this ***Notice of Privacy Practices*** from this client or client's personal representative, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented obtaining the acknowledgement
- ☐ Other (Please specify): _____

_____

_____

_____

_____ _____

Authorized BLC Signature Date

This form will be maintained in your medical record.