COLUMBIA NORTHEAST COUNSELING SERVICES

P.O. Box 4265
West Columbia, SC 29171
PHONE 803-782-5556 FAX 803-788-0914

DEMOGRAPHIC INFORMATION

Name: _____ DOB:____/____/_____
Last First Middle

Street Address:_____

City: _____ State: _____ Zip: _____ Sex at Birth: ☐Male ☐Female

Telephone: (H.) _____ (C.) _____

Email Address: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced

Children: (Names and Ages)
1. _____ 2. _____
3. _____ 4. _____

Occupation: _____

Religious Affiliation: _____

Emergency Contact Name: _____
Emergency Contact Phone Number: _____

Name of Your Insurance Company: _____
Insurance Address: _____
Primary Card Holder: _____
Relationship to Patient: ☐Self ☐Spouse ☐Child/Parent
Insurance ID Number: _____
Security Number: _____-____-_____

Name of Employer Holding the Policy_____

Employee Assistance Program: _____Number: _____

CONFIDENTIALITY

I place a high value on the confidentiality of the information that clients share. This sheet was prepared to clarify my legal and ethical responsibilities regarding this important issue.

RELEASE OF INFORMATION TO OTHERS: If for some reason there is need to share information in your record with someone not employed here (physician, family member), you will first be asked to sign a "Release of Information" authorizing your counselor to transfer the information.

EXCEPTIONS TO CONFIDENTIALITY: There are several important instances when confidential information may be released to others WITHOUT your permission.

1. IF YOU THREATEN TO HARM YOURSELF OR SOMEONE ELSE and your threat is believed to be serious, I am obligated under the law to take whatever actions seem necessary to protect you or others from harm.

2. If we have reason to believe that you are ABUSING OR NEGLECTING A CHILD OR ELDERLY PERSON, I am obligated by law to report this to an appropriate state agency. This law also applies if you report that you have reason to believe ANOTHER PERSON is abusing or neglecting the same.

3. If you have been REFERRED TO THIS AGENCY BY THE COURT (Court Ordered) you can assume that the court wishes to receive some type of report or evaluation.

4. If you are INVOLVED IN LITIGATION OF ANY KIND and you inform the court of the services that you received from us (MAKING YOUR MENTAL HEALTH AN ISSUE BEFORE THE COURT), you may be waiving your right to keep your records confidential.

In summary, I make every effort to safeguard the personal information which you share with me. However, there are exceptions listed above which are mandated by law and I want you to be fully aware of them BEFORE counseling begins.

Your signature below lets us know you have read this and understand.

____/____/_____ _____

Date Client's Signature

Columbia Northeast Counseling Services, LLC
Phone: 803-782-5556

Initial Contract

Thank you for selecting Columbia Northeast Counseling Services, LLC for your therapy and/or evaluation needs. So that we may prevent any misunderstanding regarding our policies, we ask that you read and sign this explanation of our policies.

Appointments:

- All new patients will have new patient forms that need to be completed. There are two means to accomplish this; 1) through our online patient portal when emailed, 2) print and complete the required paperwork from our website (www.colanecounseling.com).
- From time to time schedules can change and we understand. Please call/text/email our office 24 hours in advance to let us know if you need to cancel or reschedule your appointment to avoid a late-cancellation or no-show fee. The charge for a late cancel, late reschedule, or no show is $35.00.
- Three missed consecutive appointments may terminate the counseling relationship.
- If you are 15 minutes (or more) late for your appointment, the appointment may be subject to cancellation.
- If, for any reason, the counselor must cancel an appointment, the patient will be advised at the earliest possible time and will not incur any financial penalty.
-

Emergencies/After Hours

- If you are having a life threatening medical or mental health emergency, call 911, your local emergency room, or the Suicide and Crisis Lifeline at 988.
- If you are having a non-life threatening urgent issue, then during normal business hours, the receptionist will facilitate setting up an emergent/urgent contact.

Payment Policy

- The client is responsible for payments at the time services are rendered. All co-payments are due at the time of service. Columbia Northeast Counseling Services, LLC accepts cash, personal checks, credit/debit cards, and Health Spending Account (HSA) cards. A $50.00 service charge will be assessed for returned checks.
- Exceptions to the above payment policy will be dealt with on a case-by-case basis.
- Proof of all insurance (primary, secondary, and/or EAP) benefits is **required** at your first appointment; this allows us to verify if your insurance provider is one in which we are in-network with. If you fail to present proof of insurance at time of service, your benefits may be lost and all costs for services rendered will become the client's responsibility.
- Any problem with your insurance carrier that delays or prevents payment of claims is your (the client's) responsibility.

Medical Information:

- Form fees such as FMLA, Life Insurance, and other forms will be assessed at $50.00 to $75.00 per form.
- Letters from your provider on the Medical Practice letterhead will be made available at a cost of $75.00.
- I agree I have read and understand the HIPAA Notice of Privacy Practices. Initial: _____

I have read the above policies, understand, and agree with them.

_____ _____

Patient's Signature **Date**

Columbia Northeast Counseling Services, LLC
Phone: 803-782-5556

Medical History and Self-Assessment

Family Doctor (PCP): _____

PCP Phone Number: _____

Have there been any changes in your health since your last appointment?
☐No ☐Yes
If yes, please describe:_____
_____

Are you taking any medications, including over-the-counter medications?
☐No ☐Yes
If yes, please specify name and dosage: _____
_____
_____

Do you have any problems with your health (e.g. digestive problems, chronic pain)?
☐No ☐Yes
If yes, please specify: _____
_____

[redacted]

What is happening in your life which resulted in this appointment?

_____
_____
_____

What would you like to see accomplished in therapy?

_____
_____
_____

Chief Complaints (Check all that apply to you)

☐Depression	☐Thoughts racing
☐Low energy	☐Cannot hold onto an idea
☐Low self-esteem	☐Excessive behavior
☐Poor concentration	☐Delusions/Hallucinations
☐Hopelessness	☐Not thinking clearly
☐Worthlessness	☐Feeling that you are not real
☐Guilt	☐Sleep disturbance (More/Less)
☐Lose track of time	☐Appetite disturbance (More/Less)

☐Unpleasant thoughts	☐Thoughts of hurting self
☐Anger/Frustration	☐Isolation
☐Easily agitated/annoyed	☐Sadness
☐Defies rules	☐Stress
☐Blames others	☐Anxiety/panic
☐Argues	☐Heart pounding/racing
☐Excessive use of drugs	☐Excessive use of alcohol
☐Chest pain	☐Excessive use of prescription medications
☐Trembling/Shaking	☐Sweating
☐Blackouts	☐Chills/Flashes
☐Tingling/Numbness	☐Physical abuse issues
☐Fear of dying	☐Sexual abuse issues
☐Nausea	☐Spousal abuse issues
☐Phobias	☐Obsessions/compulsive behavior

☐Other: _____

Previous outpatient therapy? ☐No ☐Yes, with _____
When? _____
What was accomplished?
_____

Previous hospitalization for mental health treatment? ☐No☐Yes
When? _____
Where? _____
Treatment: _____

Please rate how your problem(s) or emotional status are currently functioning in the following areas.

Family Relations: ☐None ☐Mild ☐Moderate ☐Severe
Work/School Performance: ☐None ☐Mild ☐Moderate ☐Severe
Social Relations:☐None ☐Mild ☐Moderate ☐Severe

_____ _____
Signature of Patient **Date**

Columbia Northeast Counseling Services, LLC
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Informed Consent to Telehealth

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinicians located at Columbia Northeast Counseling Services, LLC.

I understand I have the following rights under this agreement:

1. I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.
2. I understand that there are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental of emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.
3. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, in-person appointments can be scheduled with my therapist for a later date.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
5. I understand that Columbia Northeast Counseling Services, LLC will bill my insurance or Employee Assistance Program for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance or my Employee Assistance Program does not cover telehealth, I will be required to pay out-of-pocket on a sliding, self-pay scale. I understand that if any paperwork is required to be completed by my therapist, I am required to pay a paperwork completion charge prior to the paperwork being received.
6. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1, the Suicide Prevention and Crisis Lifeline at 9-8-8, or seek help from a hospital or crisis-oriented health care facility in my immediate area.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my

treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communications by providing written notification to Columbia Northeast Counseling Services.

My signature below indicates that I have read this Agreement and agree to its terms.

_____
Print Name

_____ _____
Client's Signature Date

_____ _____
Parent or Guardian Signature Date

Credit/Debit Card Payment Authorization Form

I have provided Columbia Northeast Counseling Services, LLC with my credit/debit card number and authorize their office to keep my signature on file, and to charge my credit card account (designated below) for all services, to include any sessions, any missed appointments, any balances, and for all third party payments paid directly to me, that were due to Columbia Northeast Counseling Services, LLC. **Columbia Northeast Counseling Services, LLC will attempt to contact you prior to charging your card for any services; however, it is MANDATORY that a card be on file. Your information will be stored in a confidential area and destroyed after use.**

I understand that this form is valid unless I cancel the authorization through written notice and that an invoice for all paid balances will be provided to the authorized cardholder, only upon direct request to the counselor.

Name on Debit/Credit Card: _____

(If a third party is the financially responsible party, client must provide a Release of Client Information Authorization).

Type of Card: ☐Visa ☐MasterCard ☐Health Savings Account (HSA) ☐Other: _____

Debit/Credit Card Number: _____

CVV #:_____ Expiration Date: _____

3-digit Security Code on back of card as provided on card

Cardholder's billing address and zip code:

_____

_____

_____ _____

Cardholder's Signature Date

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