TRINITY
FAMILY COUNSELING SOLUTIONS

Client: D.O.B:
Record #: Medicaid /#:

CLIENT IDENTIFICATION FACE SHEET

ADMISSION DATE:	DISCHARGE DATE:

Please complete the following information as complete as possible. Ask staff if you have any questions! Thank you.

Title:	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other:				
Last Name:					
First Name:					
Middle Name:					
Preferred Name:		Maiden Name:			
Address:	Street Address:				
	City:	State:	County:	Zip Code:	
List Preferred Contact:	Phone Home:	Office:	Cell:	Email:	

I give TFCS permission to leave detailed messages on my listed phone/email. **(SIGN & DATE)**_____

DEMOGRAPHIC INFORMATION

Date of Birth:		Social Security #:	Gender: ☐ Male ☐ Female	Primary Language:
Race:	☐ Alaskan Native ☐ American Indian/Native American ☐ Asian ☐ Black/African American ☐ Multiracial ☐ Pacific Islander ☐ Other ☐ Unknown ☐ White			
Ethnicity:	☐ Not Hispanic ☐ Hispanic, Cuban ☐ Hispanic, Other ☐ Hispanic, Puerto Rico ☐ Unknown			
Marital Status:	☐ Annulled ☐ Divorced ☐ Domestic Partners ☐ Single/Never Married ☐ Married ☐ Separated ☐ Unknown ☐ Widowed			
Employment:	☐ Unemployed ☐ Full Time ☐ Part-time ☐ Student ☐ Retired ☐ Homemaker ☐ Not Available ☐ Armed Forces ☐ Seasonal / Migrant ☐ Other Place of Employment: Job Title: Length of employment:			
Education:	Highest grade completed:_____ Currently enrolled in educational program: ☐ No ☐ Yes If yes what level/where:			
Military:	☐ NA ☐ Yes	Branch:	Years of service:	Type of discharge:

CONTACT INFORMATION

Contact Person Parent(s)/Legally Responsible Person/ Significant Other:	
Address/Phone:	Street Address:
	City State Phone#

INSURANCE

Medicaid #:		Other Insurance:	Company:
			ID Number:

TRINITY
FAMILY COUNSELING SOLUTIONS

Client: D.O.B:
Record #: Medicaid /#:

EMERGENCY INFORMATION, CONSENT AND CONTACTS

ALLERGIES:

Name:	SS#:	DOB:

Address:
Street Apt# City State Zip Code

Phone: home: work: cell:

PERSON TO CONTACT IN CASE OF EMERGENCY

1st Contact Name:	Relationship:	Address:

Phone: home: work: cell:

2nd Contact Name	Relationship:	Address:

Phone: home: work: cell:

MEDICAL HISTORY **H = History/Past** **C = Current**

☐H ☐ C	Arthritis	☐H ☐ C	Cancer	☐H ☐ C	Lung/breathing problems	☐H ☐ C	Epilepsy
☐H ☐ C	Heart Disease	☐H ☐ C	Hepatitis	☐H ☐ C	High/low Blood Pressure	☐H ☐ C	Kidney Disease
☐H ☐ C	Strokes	☐H ☐ C	Convulsions	☐H ☐ C	Frequent vomiting	☐H ☐ C	Diabetes
☐H ☐ C	Cirrhosis	☐H ☐ C	Herpes	☐H ☐ C	HIV/AIDS	☐H ☐ C	Other STDs
☐H ☐ C	Thyroid	☐H ☐ C	Pancreatitis	☐H ☐ C	Severe headaches	☐H ☐ C	Head injury
☐H ☐ C	Weight gain	☐H ☐ C	Weight loss	☐H ☐ C	Fainting spells	☐H ☐ C	Gout

List any other health problems:

List any surgeries you have had in the last 2 years:

CURRENT PRESCRIBED MEDICATIONS

Name	Dosage	Frequency	Route of Administration	Reason	Prescribed by

OVER-THE-COUNTER MEDICATIONS

Name	Amount	Frequency	Reason

MEDICAL INFORMATION

Name of Practice	Location	Phone

Hospital Preference:

Insurance Name: Policy #:

By signing this form I am agreeing for Trinity Family Counseling Solutions to provide emergency First Aid services to me in case of an injury or emergency. I agree for my Emergency Contact Person to be contacted. EMS and Mobile Crisis will be given a copy of this form. It is understood and agreed TFCS will be held harmless for any and all results of the staff's efforts to obtain emergency medical treatment including any accident or injury while being transported. I will assume the full responsibility of all incurred emergency treatment expenses.

I understand and give consent for this information to be used ONLY in case of an emergency medical situation. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Other Drug Abuse Patient Records, 42 CFR, Part 2 and HIPAA and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

TRINITY
FAMILY COUNSELING SOLUTIONS

Client: D.O.B:
Record #: Medicaid /#:

AUTHORIZATION FOR DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

I hereby request and authorize **Trinity Family Counseling Solutions, 1600 E Wendover Ave, Suite R *Greensboro*** to disclose to, receive from and communicate with:

_____
Individual/Organization/Program Address Phone

The following protected health information: (**please initial** each that applies/leave blank if not requested)

___ Assessment & Diagnosis
___ Treatment plan
___ Discharge Summary
___ Progress notes
___ Financial Information
___ Unlimited Disclosure
___ Other: _____
___ Psychological Evaluation
___ Psychiatric Evaluation
___ Medical records
___ School Records
___ Appointment Coordination
___ Drug Screen Results

The purpose of disclosure is:
___ Continuity of care between providers
___ Information for significant others
___ Information for treatment planning
___ Information for billing purposes
___ Information for court/judicial/attorney
___ Other _____

Redisclosure of protected health information is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" for substance abuse treatment and under state law G.S. 122C for mental health and developmental disabilities.

I understand that if my record contains HIV infection, AIDS or AIDS related conditions information it can only be disclosed in accordance with the communicative disease as specified in GS 130A-143. TFCS will only disclose information when I sign specifically for release of HIV/AIDS release.

I may revoke this authorization at any time. I understand that any action taken on this authorization prior to the date I revoke it is legal and binding. I understand I may revoke this authorization by writing a letter or verbally telling the TFCS staff person I work with or by calling the Privacy Officer.

I certify that this authorization is made freely, voluntarily, and without coercion. I may refuse to sign this authorization form and TFCS will not condition my treatment on receiving my signature on this Authorization.

The date this consent expires: _____.

Client/Legally Responsible Person/Personal Representative Signature:	Date
Staff Signature	Date

REVOCATION OF AUTHORIZATION/CONSENT

I withdraw the authorization to disclose personal health information of _____
(Verbal Request by: _____) Effective on: _____

_____ _____
Client/Legally Responsible Person/Personal Representative Signature Date

_____ _____
Staff Signature Date

TRINITY
FAMILY COUNSELING SOLUTIONS

Client: D.O.B:
Record #: Medicaid /#:

AUTHORIZATION FOR DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

I hereby request and authorize **Trinity Family Counseling Solutions, 1600 E Wendover Suite R, *Greensboro*** to disclose to, receive from and communicate with:

_____

Individual/Organization/Program Address
Phone

The following protected health information: (**please initial** each that applies/leave blank if not requested)

___ Assessment & Diagnosis
___ Treatment plan
___ Discharge Summary
___ Progress notes
___ Financial Information
___ Unlimited Disclosure
___ Other: _____
___ Psychological Evaluation
___ Psychiatric Evaluation
___ Medical records
___ School Records
___ Appointment Coordination
___ Drug Screen Results

The purpose of disclosure is:
___ Continuity of care between providers
___ Information for significant others
___ Information for treatment planning
___ Information for billing purposes
___ Information for court/judicial/attorney
___ Other _____

Redisclosure of protected health information is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" for substance abuse treatment and under state law G.S. 122C for mental health and developmental disabilities.

I understand that if my record contains HIV infection, AIDS or AIDS related conditions information it can only be disclosed in accordance with the communicative disease as specified in GS 130A-143. TFCS will only disclose information when I sign specifically for release of HIV/AIDS release.

I may revoke this authorization at any time. I understand that any action taken on this authorization prior to the date I revoke it is legal and binding. I understand I may revoke this authorization by writing a letter or verbally telling the TFCS staff person I work with or by calling the Privacy Officer.

I certify that this authorization is made freely, voluntarily, and without coercion. I may refuse to sign this authorization form and TFCS will not condition my treatment on receiving my signature on this Authorization.

The date this consent expires: _____.

Client/Legally Responsible Person/Personal Representative Signature:	Date
Staff Signature	Date

REVOCATION OF AUTHORIZATION/CONSENT

I withdraw the authorization to disclose personal health information of _____
(Verbal Request by: _____) Effective on: _____

_____ _____
Client/Legally Responsible Person/Personal Representative Signature Date

_____ _____
Staff Signature Date

TRINITY
FAMILY COUNSELING SOLUTIONS

Client: D.O.B:
Record #: Medicaid /#:

CONSENT TO BILL INSURANCE

I understand the services provided by TFCS, as described in my plan of care are to be billed to Medicaid or other insurance. I understand that I will be responsible for payment of deductibles, co-payments, non-covered services and/or balance amounts.

SOCIAL SECURITY NUMBER: _____ - _____ - _____

Initial by the statement(s) that describe your insurance benefits

_____ **I have NC Medicaid and/ or NC Health Choice coverage**. I will need to provide TFCS with my current Medicaid and/or Health Choice eligibility card and the updated eligibility cards so my claim can be filed.

_____ **Insurance or other medical coverage** I have medical insurance coverage; I will bring in necessary insurance information and documents to allow TFCS to file with certain insurance companies for certain services. I will make regular payments according to my payment plan below while my insurance is being processed and as needed after my insurance has paid TFCS.

_____ **Assignment of Benefits** I hereby authorize payment directly to TFCS Healthcare of benefits otherwise payable to me (insurance and other third party reimbursement).

_____ **Release of Information** I hereby authorize TFCS to release specified information in my client record to my insurance company. This data shall include any information necessary to file any insurance claim and/or third party reimbursement on my behalf. The specific purpose of this information is to collect fees for services rendered to me. This consent shall be valid for 1 (one) year. The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ _____
Client/ Legal Representative Signature & Date Staff / Witness Signature & Date

---

FEE CONTRACT

If I do not have any insurance I am responsible for payment as determined by the Agency Director

_____ **Reduced Payment** I understand inability to pay must be proven and negotiated on an individual basis. If I do not have insurance and/ or my family size and income are within federal guidelines, I might be able to pay reduced payments. **AMOUNT:** _____

_____ I do not wish to disclose, or have not disclosed , information regarding my household income as requested. **I am therefore aware that I am fully responsible for the full fee charged for services**.

_____ **Payment Plan** My fees have been set up on a payment plan. I will make payments until my account is paid in full.
____ Weekly ____ Two Weeks ____ Monthly ____ Other _____

Amount $_____ Date payments to begin: _____

Signature of Client:	Date:
Signature of Parent/Guardian/Person Legally Responsible:	Date:
Signature of Staff:	Date:

Amaya Hardy
Licensed Clinical Mental Health Counselor (LCMHC)
License #11986
Professional Disclosure Statement & Informed Consent

Phone: 336-541-6242
Qualification/Experience: I graduated from Liberty University in May 2014 with a Master of Arts degree in Marriage and Family Therapy. I hold a Bachelor of Science degree in Psychology from North Carolina Agricultural and Technical State University (May 2008). I began my professional work in the mental health field following the completion of my bachelor's degree. I began my work as an Intensive In-home AP. The last position I held in the mental health field, I served as an Intensive In-home Team Lead. I have over 10 years of experience of working with children, adolescents, adults, couples, and families. It has been my passion to service women, children and their families.
Restricted Licensure/Consultation: I am fully licensed as a Licensed Clinical Mental Health Counselor in the state of North Carolina.
Counseling Relationship: There are many reasons people seek counseling. Each individual has unique counseling needs and challenges they seek to address through therapy. There isn't a single-handed approach that will work for everyone; however, by providing Faith based Christian counseling and assisting those who actively seek counseling in building healthy relationships with themselves, God, and others, I hope to help others improve their mental wellness. Along with Faith based and Biblical Counseling, I utilize integrative and evidence-based models that are based from Cognitive Behavioral Therapy, Solution Focused, Motivational Interviewing, Forgiving and Trauma-Informed approaches.
I do not engage in social relationships with clients via social media, or in social settings outside of the therapy office. Your public confidentiality is also entitled to respect. We may encounter one another outside the office by chance. To protect your privacy, I will not acknowledge that we are acquainted; however, if you choose to greet me I will happily do likewise.
Use of Diagnosis: If you elect to use your health insurance to receive services, I must make a formal mental health diagnosis in order to get sessions authorized. The clinical diagnosis will become a part of your permanent record. Additionally, if you wish for your protected health information to be released to someone, you must sign a specific release of information. Insurance companies and other third-party payers are given the following information upon request: type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy and summaries. This information is subject to review and has the potential of effecting medical records, disability claims and benefits. I will inform you of the diagnosis before we submit the diagnosis to the health insurance company.
Appointment and Fee Information: Fees for family based services will be $170.00. Fees for individual 60-minute therapy sessions will be $125.
A sliding fee scale is available upon request and is based on household income level. I also provide services for individuals that have Aetna, Blue Cross Blue Shield, United Healthcare, Humana, and Cigna.
Fees are due at the beginning of each session in the form of cash, Visa of MasterCard.
Clients are seen by appointments only.
If you must cancel or reschedule an appointment, please notify the office at (336) 541-6242 within 48 hours to avoid being charged $50 for the missed appointment. If you are late for an appointment, I will be happy to see you for the remaining time available, but you will be expected to pay your normal fee.

My agreed fee per session is: _____ Initials: _____ Date:___/_____/____

Office Hours: My office hours are Monday-Friday 8am-6pm.

Emergency/Crisis: I do provide emergency crisis services at this time. In the event of a medical emergency please call 911. In the event of a Mental Health crisis please call the (877) 626-1772 and I will return your call.

Confidentiality: All interactions between you and I are confidential. I will protect this information with the utmost care and respect. However, exceptions to confidentiality do exist: (a) if you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself, or others or to child & adult/elder abuse (c) I am ordered by a court to disclose information.

Complaint Procedures: I encourage you to discuss any concerns or questions you may have regarding my services with me. This will allow our work together to be more collaborative in nature. If I am unable to resolve your concern, you may file a complaint against me to the North Carolina Board of Licensed Clinical Mental Health Counselors. You may also report complaints to the organization below should you feel I am in violation of any of the code of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/CodeofEthics/TP/Home/CT2.aspx).

North Carolina Board of Licensed Clinical Mental Health Counselors
PO BOX 77819 Greensboro, NC 27417
Phone: 844-622-3572
Fax: 336-217-9450
Email: LCMHCinfo@NCBLCMH.org

By signing this document, I indicate that I have read, understood, and agreed to the information included in this document, and that any questions I have in regards to this form have been answered to my satisfaction.

_____
Printed Name of Client or Parent/Guardian

_____
Signed Name of Client or Parent/Guardian

___/___/___
Date

_____
Printed Name of Counselor

_____
Signed Name of Counselor

___/___/___
Date