

TICS No Show, and Late Cancellation Policy

1. I understand that my credit/debit card on file will be charged a LATE CANCELLATION fee of \$55.00 if I do not to give at least 24-hour notice prior to canceling my appointment.

2. I understand that my credit/debit card on file will be charged a NO-SHOW fee of \$55.00 if I do not show for my scheduled appointments.

3. I understand that after the initial session, therapy sessions will last 50 minutes. I understand that if I am late to my appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive.

Print full name

Signature of Responsible Party

Date

Counselor's Signature and Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. It is my professional and ethical responsibility to assure you that I will hold your personal information in the strictest confidence. I am required by applicable Federal and North Carolina State law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligation, and your rights concerning your Protected Health Information, or PHI. I must follow the privacy practices described in this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written Authorization:

I may use and disclose PHI without your written authorization, excluding Notes and Reports, as described in Section II, for certain purposes described below.

1. **Treatment:**

I may use and disclose PHI to provide treatment to you. For example, I may use PHI to diagnose and provide counseling services to you. In addition, I may disclose PHI to other health care providers involved in your treatment. This may include referrals to other clinicians that are bound by the same mental health confidentiality laws.

2. **Required or permitted by law:** I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:

a) **Duty to warn:** Your PHI may be disclosed if I determine a need to alert an intended victim of a serious threat to their health. For example, this may occur if you reveal intentions to harm another person. I am obligated to take necessary action to avert a serious threat to the health or safety of others.

b) **Danger to self:** Your PHI may be disclosed if I determine that you may seriously harm yourself.

c) **Child or elder abuse or neglect:** Your PHI may be disclosed if you report or I reasonably suspect any child or elder abuse or neglect.

d) **Court order:** Your PHI may be disclosed if I am presented with a court order to do so.

e) Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon due date.

B. Uses and Disclosures Requiring Your Written Authorization

1. Counseling Notes:

Notes recorded by me documenting the contents of a counseling sessions will be used only by me and will not otherwise be used or disclosed without your written authorization.

2. Marketing communications:

I will not use your health information for marketing communications without your written authorization.

3. Payment: I may not disclose PHI to your insurance company for payment purposes without your written authorization.

4. Other Uses and Disclosures:

Uses and disclosures other than those described in Section I, will only be made with your written authorization. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. **You have the right to Inspect and Copy:**

You may request access to your medical and/or billing records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. Otherwise, this information must be released within 15 days. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor 13 years of age or older, please note that certain portions of the minor's medical record will not be accessible to you, such as records relating to mental health treatment (age 13 and older), substance abuse treatment (age 16 and older), sexually transmitted diseases (age 14 and older), or abortions (age 14 and older), unless your minor child has provided written authorization to do so.

B. **Right to Alternative Communications:** You may request, and I 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 writing address to me, the "Privacy Officer, "as indicated below. I am 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 me. This right applies to disclosures for purposes other than treatment, payment of health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. It is my obligation to you to inform you if there are any unauthorized releases of your PHI by me. If a breach of your PHI has been made I will explain the possible scope of the disclosure, the risks associated, and the steps I have taken/will take to deal with the breach.

E. **Right to Request Amendment:**

You have the right to request that I amend your PHI. Your request must be in writing and it must explain why the information should be amended. I must respond to your request within ten (15) days. I may deny your request under certain circumstances. In this event, a "Statement of Disagreement" based upon your proposed amendment, must be added to your record.

F. **Right to Obtain Notice:**

You have the right to obtain a paper copy of this Notice by submitting a request to me, the Privacy Officer, at any time.

G. **Questions and Complaints:**

If you desire further information about your privacy rights, or you are concerned that I have violated your privacy rights, you may contact me, Travis E. Williams M.Ed., LPC, CRC by telephone at (984) 664-4105 or in writing at 5300 Atlantic Ave. Suite 106-B Raleigh NC 27609.

You may also file written complaints with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you if you file a complaint with me or the Department of Health.

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III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date:

This Notice is effective on _____

B. Changes to this Notice: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I (print your name) _____, acknowledge that I received a copy of the Notice of Privacy Practices for TICS, PLLC. This Notice describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of health care system operations. The Notice of Privacy Practices also describes my individual rights and responsibilities, and the duties of TICS, PLLC with respect to my protected health information.

Client's signature and date:

Counselor's signature and date:

This form will be retained in the mental health record.

FOR OFFICE USE ONLY

I attempted to obtain signed Acknowledgment of Receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained for the following reason:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency prevented me from obtaining Acknowledgment
- Other:

TICS Counseling Intake Form

Today's Date: _____

Last Name: _____ First Name: _____

M.I. _____ Age: _____ DOB: _____ Sex: _____ Gender _____

Race _____

Current address: _____ City _____ Zip _____

Phone Number: _____ Alternate Phone Number: _____

Email: _____

Will you be filing with your insurance? Yes or No

Primary insurance company _____

Member ID Number _____

Secondary Insurance company _____

Member ID number _____

What would like to accomplish during your counseling sessions?

Do you have any reservations about participating in counseling? If yes, please explain?

Please check any of the following that apply to you?

- Anxiety
- Difficulty Communicating with others
- Depression
- Marital Problems
- Lack of Focus
- Sexual Addiction/Pornography
- Panic Attacks
- General and consistent feelings of unhappiness
- Irritability
- Fatigue
- Anger Issues
- Hallucinations

- Issues with High School or College Transition
- Trauma
- Issues in School
- Crying Spells
- Substance Use
- Persistent Overwhelming Guilt
- Avoidance of Others
- Problems with adjusting to a significant life event

Physical Health History

Describe any previous medical diagnoses.

Current medications?

Do you exercise regularly? Yes No

If yes, how often _____

Mental Health History

Previous mental health diagnoses?

Dates treated?

Name of your previous therapist? _____

His or her telephone? _____

Previous Therapist address? _____

TICS

Have you ever had feelings or thoughts that you didn't want to live? Yes No.

If YES, please answer the following. If NO, you may skip to the next section.

Do you currently feel that you don't want to live? Yes No

How often do you have these thoughts?

Has anything happened recently to make you feel this way?

Have you ever tried to kill or harm yourself before?

Do you have access to guns? If yes, please explain.

Substance Use

Have you ever been treated for alcohol or drug use or abuse? Yes No

If yes, for which substances?

If yes, where were you treated and when?

Do you think you may have a problem with alcohol or drug use? Yes No

Have you used any street drugs in the past 3 months? Yes No

If yes, please describe?

Have you ever abused prescription medication? Yes No
If yes, please describe?

Tobacco History:

Have you ever smoked cigarettes? Yes No

Currently? Yes No How many packs per day on average? _____ How many years? _____

In the past? Yes No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? Yes No In the past? Yes No

Relationship History

Are you currently: Married Partnered Divorced Single Widowed

How long? _____

If not married, are you currently in a relationship? Yes No If yes, how long? _____

Describe your relationship with your spouse or significant other?

Have you had any prior marriages? Yes No If yes, how many? _____

How would you identify your sexual orientation? _____

Are you sexually active? Yes No

Do you struggle with persistent urges to view Pornography? Yes No

Has your spouse criticized you for viewing Pornography? Yes No

If yes, please explain?

Do you struggle with having intimacy with your spouse? If yes, please explain,

Family History

Is there any family history of mental health diagnoses or mental health treatment in your family?

Any history of suicide or suicide attempts in your family?

If yes, please describe their relationship to you?

Do you have a history of being abused- emotionally, sexually, or physically? Yes No. If yes, please describe when, where and by whom?

Has anyone in your immediate family died recently, if yes please describe?

Social

Highest education completed?

Have you ever served in the military? If yes, provide dates of Service and branch

Highest rank?

Honorable discharge Yes No If No, please explain?

Are you currently: Working Student Unemployed Disabled Retired

How long in present position?

What is/was your occupation?

Where do you work?

How satisfied are you with your currently employment situation?

Legal History

Have you ever been arrested? Yes No

If yes, please explain circumstances and dates?

Do you have any pending charges, please describe?

Spiritual Life:

Please describe your faith.

Are you satisfied with this aspect of your life?

Client Signature and Date

If under 18years of age Parent/Guardian Signature and Date

Counselor's Signature and Date

TICS

Credit Card Authorization

Your provider requires you to provide your credit/debit card information on file with us so we can automatically charge any co-pays, co-insurance, deductible amounts, and professional service charges such as late cancelation or missed appointment charges. It is the client's responsibility to keep cards accurate and up to date. We store financial information and other protected health information in an encrypted, HIPAA compliant site. Payment is required at the time of service. If balance accrues and no payment is received, we reserve the right to seek payment by any means, including using the credit/debit information we have on file, retaining the collection agency, and taking legal action in court. We may be willing to work out a client payment plan that includes a reasonable period for resolving the balance. If the client's balance remains unpaid, we reserve the right to suspend services until the balance is paid in part or in full.

Name on Card: _____

Address: _____ City: _____
_____ State: _____ Zip Code: _____

Credit Card # _____ Exp: _____
_____/_____ Security Code: _____

Signature of card holder: _____ Date: _____
