CARTER'S COMPASSIONATE COUNSELING SERVICES, LLC

320 REMINGTON DR., BRANDON, MS 39042
4659 TERRY RD.,
Jackson, Mississippi 39212
(601) 668-1221

Email: caleicha@gmail.com

Confidential Information Sheet

Today's Date: _____

Client Name: _____

Parent/Guardian name: _____

Date of birth: _____ Age: _____ Social Security #: _____

Preferred Phone: (____) _____ Ok to leave message? ___ Yes ___ No
Alternate Phone: (____) _____ Ok to leave message? ___ Yes ___ No

Permanent Address: _____
Street City State Zip

Emergency Contact: _____Relationship: _____ Phone: _____

Gender: ___ Male ___ Female ___ Other Race: _____ Any physical impairment? _____

Please check all of the following items, which are concerns at this time and circle those, which are most important.

Abortion issues	Abuse-emotional, physical, verbal, sexual neglect	Academic issues	Alcohol issues
Anger, arguing	Compulsive behaviors	Anxiety, nervousness	Behavior problems
Body Image	Drug use	Concentration	Decision making, indecision
Depression, sadness, crying	Family relationships Grief issues	Eating problems	Emptiness
Divorce, separation of parents	Grief issues	Fearing failure	Fears, phobias
Intervention plan needed	Hallucinations	Guilt	Harassment
Perfectionism	Learning disability	Identity issues	Impulsive, out of control
Pregnancy	Need testing	Loneliness, no friends	Moods swings
Relationship violence	Peer relationship concerns Racial/ethnic concerns	Parent deployment to war	Panic attacks
Self-injury, mutilation	Racial/ethnic concerns	Repeated troubling thoughts	Picking fights with peers
Sexual harassment	Romantic relationship	Sexual assault	Relationship concerns
Sleep problems	Self-neglect, poor self-care	Shyness, oversensitive	Self-esteem issues
Trauma	Sexual orientation/identity	Suicidal thoughts	Sexual concerns
	Stress	Withdrawal, isolating	Smoking, tobacco use
	Violent thoughts		Tiredness, fatigue
Name/ signature of Person completing form:		Date:	Other concerns:

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Client Face Sheet

Client ID: *Presenting Problem:* ___*New* ___ *Established* *Date:*

	Therapist/Case Manager	*Referred By:* *(1) Parent/Guardian_____* *{3) Community Agency __* *{2) School Staff_____* *(4) Mental Health Facility____* *(5) Other:*

Last Name, First, Middle: *Maiden Name: (If Applicable)*	*Treatment Category: MH ___ MR ___ SA ___ Dual ___* *Primary Treatment Category (if dual): _____*
Address: Street, City, County, State ,Zip:	*Home Number:*

Is individual Pregnant? ___ Yes ___ No Is Client Seriously Mentally Ill? ___ Yes ___ No

Is client seriously emotionally disturbed child? ___ Yes ___ No

Social Security Number:	Date of Birth:	Age:	Gender: __Male __Female
Race: __ African American __Asian __Caucasian __Hispanic (Origin:_____) __Native American __Other	Marital Status: __Married __Single __Divorced __Widowed __Separated __Other	Residential Arrangements: __Private Residence __Homeless __Institution __Community Program __Correctional Facility __Other	Living Arrangements: __Live alone __Live w/ Relatives __Live w/ Non-relatives __Other Number of persons in household depend on income:____

Physical Impairment:		Disability Category:	
__Deafness & Blind	__Unable to communicate	__Mental Health	__MR/SA
__Deafness/Sever hearing loss	__Brain injury	__Develop Disability	__MH/MR/SA
__Blind/Severe Vision loss	__Major Medical Condition	__Substance Abuse	__Unknown
__Non-ambulatory	__Other	__MH/MR	Eligibility for SSI/SSDI__Yes__No__Unknown
__Ambulatory w/ assistance	__Unknown	__MS/SA	Eligible for Medicaid __Yes __No__Unknown

Legal Status:	Veteran Status:	Household Income Source:
__Voluntary	__Yes, I'm a Veteran	__Wages/Salary __Other
__Other legal status	__No, I'm not a Veteran	__Public Assistance __None
__Probation/Parole	__Other	__Retirement/Pension
__Other		__Disability Annual Income:_____

Education:		Employment Status:	
__Enter highest grade attended	__Associate Degree	__Full-time	__Student/Under 17
__Preschool/Kindergarten	__Bachelor's Degree	__Part-time	__Retired
__Special Ed	__Master's Degree	__Active military	__Disabled
__GED	__PhD	__Unemployed	__Correctional Inmate
__Tech/Trade School	__None	__Homemaker	__Other
__Some College, No degree		Expected principle source of payment: _____	

Emergency Contact and Phone Number:

PATIENT INFORMATION UPDATE

Student's Name: _____ Date: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Home Phone:_____ Cell phone:_____Work phone:_____

DOB: _____ Age: _____ Sex: _____ SSN: _____

School: _____

Parent/Guardian's Name: _____

Emergency Contact: _____ Phone#: _____

BILLING INFORMATION

Name of Guarantor: _____

Address: _____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Work Phone: _____

Date of birth: _____SSN: _____

Age: _____ Sex: _____Home Phone: _____Cell phone: _____

Employer: _____Work phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber: _____DOB: _____

Member/ID#: _____ Group #: _____

Address: _____

City: _____State: _____Zip: _____ Phone #: _____

Effective Date: _____ Deductible: _____ Co-Pay: _____

Secondary Insurance: _____

Subscriber: _____DOB: _____

Member/ID#: _____ Group #: _____

Address: _____

City: _____State: _____Zip: _____ Phone #: _____

Effective Date: _____ Deductible: _____ Co-Pay: _____

Client Bill of Rights

You have the right to:

- Get respectful treatment that will be helpful to you.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Report immoral and illegal behavior by a therapist.
- Ask for and get information about the therapist's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist thinks will be needed, substitute therapists (in cases of vacation and emergencies), and cancellation policies.
- Refuse audio or video recording of sessions (but you may ask for it if you wish).
- Refuse to answer any question or give any information you choose not to answer or give.
- Know if your therapist will discuss your case with others (for instance, super-visors, consultants, or students).
- Ask that the therapist inform you of your progress.

_____

Client Signature Date

_____

Therapist Signature Date

Informed Consent for Participation in Therapy or Evaluation

I hereby apply for consent to therapy or an evaluation at Carter's Compassionate Counseling Services, LLC. I understand that it is of critical importance to the staff at Carter's that the confidentiality of each client is protected. Counseling staff may consult with one another about my treatment only to enhance the quality of services I receive and ensure the continuity of care in clinical emergencies. All information obtained from me and my family will be held in the strictest confidence legally possible. Information and records regarding my treatment will not be released to other individuals or agencies without my written permission. In the case of couples (marital counseling), both parties must give consent for the release of records. There are, however, four conditions under which confidentiality must be broken: 1) in the case that a therapist has reason to believe that the client is at imminent risk of doing harm to her/himself; 2) in the case that a therapist has reason to believe that a client is at imminent risk of doing serious harm to others; 3) in the case that a therapist has reasonable cause to believe that a child or vulnerable adult has been physically or sexually abused or neglected by a parent or caretaker; and 4) In the case that therapist is ordered to do so by a judge in a court of law. As a client or visitor of this facility, I agree to protect the confidentiality of all parties. I will keep private anything that I hear or see as it relates to others.

Non-Discriminatory Policy
I understand that Carter's Compassionate Counseling Services, LLC, does not discriminate against any person based on race, color, national origin, disability or age in admission, treatment or participation in its programs, services and activities or in employment. For further information, please contact Aleicha Carter.

Professional Fees
I understand that the fee is $300.00 for the initial visit, $250.00 per hour and $125.00 per half hour each session thereafter. I also understand that it is your practice to charge this amount for other professional services that may be required such a litigation and phone consultation. I understand that fees for psychological assessments are based on the type of assessment performed. These rates will be discussed with me. I am expected to pay for each session at the time it is held, if I have not met my deductible. The exception is for clients who have been referred by their EAP provider. The co-payment is expected for each session when held.

Authorization for Release of Medical Information for Billing and Payment
I authorize Carter's Compassionate Counseling Services, LLC, to release to the insurers or to any agency concerned with the payment of my charges, any and all medical information, by phone, mail, fax or electronic mail, including copes of records, and any and all information which are deemed by insurers or other agencies, to be required in the processing of applications for financial coverage for services rendered.

Assignment of Benefits
Notwithstanding the Undersigned's personal guarantee to pay any and all charges incurred for treatment, the Undersigned hereby assigns direct payment of any insurance benefits, medical insurance benefits, insurance sick benefits, or injury benefits payable because of liability of a third party or by any party or organization and so forth, payable to or for the Patient until PROVIDER is paid in full.

Contacting Carter's
During business hours, my therapist may not be immediately available by telephone, as he/she will not answer the phone when with a client. When unavailable, the telephone will be answered by the office staff or by voicemail, which is monitored frequently. My therapist will make every effort to return my call as soon as possible. After business hours, if I am experiencing a crisis, I understand I should go to the nearest emergency room.

Minors
If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is our policy to request an agreement from your parents that they

consent to give up access to your records. If they agree, we will provide them only with general information on how your treatment is proceeding, unless we feel that there is a high risk that you will seriously harm yourself or another, in which case we will notify them of that concern. We also provide them with a summary of your treatment when it is complete. Before giving them any information, we discuss the matter with you and will do the best we can to resolve any objections you may have about what we are prepared to discuss.

I have read the above statements and my questions about therapy have been answered to my satisfaction. I understand that I have further questions, that my therapist will either answer them for me or find appropriate answers. I understand that I may leave therapy at any time, although I have been advised that this best done in consultation with my therapist.

_____ _____

Signature Date Signature Date

I hereby consent to the above for _____ as a minor or person unable to assume personal responsibility.

_____ _____

Signature Date Relationship to Client

_____

Signature of Witness Date

Agreement for Individual Therapy

I, _____, the client agree to meet with the therapist named below at the appointment times and places we agree on, starting_____, 20____ for about _____sessions of _____ minutes each.

I believe I understand the basic ideas, goals, and methods of this therapeutic private practice. I have no important questions or concerns that the therapist has not discussed. In my own words, The reasons for me seeking therapy is because: _____

_____.

During these sessions, we will focus on working towards these goals: _____

_____.
I understand that reaching these goals is not guaranteed.
I understand that I will have to do the following things/take the following actions: _____

_____.

Without enough knowledge, and without being forced, I enter into treatment with this therapist. I will keep my therapist fully up to date about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work out in my long-term best interest.

At the end of meetings, we will evaluate progress and may change parts of this agreement as needed. Our goals may have changed in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will attempt to make change in this agreement, and I may stop treatment after giving this therapist at least 7 days' notice of my intentions and meeting with the therapist for one last time.

This agreement shows my commitment to pay for this therapist's services. It shows this therapist's willingness to use and share his or her knowledge and skills in good faith. I agree to pay $____ per session, and to pay at the end of each session. I agree to pay for uncancelled appointment of those where I fail to give enough notice that I will not attend. The only exceptions are unforeseen or unavoidable situations arising suddenly. I understand and accept that I am fully responsible for this fee, but that my therapist will help me in getting payments from any insurance coverage I have. I understand that this agreement will become part of my record of treatment.

I also give my permission for the therapist to audiotape/videotape our sessions for personal review and use with a consultant, who is also bound by the legal framework of privacy and confidentiality. I understand that any information in this recording that could identify me in any way will not be published or given out without my written consent. My signature below means that I understand and agree with all of the points above.

Signature _____ Date _____