Jennifer Coleman, MS, EdS, LPCA

Individual Intake Form

Date: _____ **Referral Source:** _____

Client Name: _____ **D.O.B.** _____

Address: _____

_____

Phone Number: _____

Email Address: _____

Emergency Contact: _____
(Name/Relationship)
(Phone Number) _____

Household Residents (other than yourself - name, age, relationship):

_____

_____

_____

Medical Information: Please list any current medical issues and the doctor you see for that issue (name and phone number).

_____

_____

_____

Any other helping professionals you see (name and phone number):

_____

_____

_____

Please list any current medications you are prescribed:

_____

_____

_____

What brings you to counseling?

_____

_____

_____

_____

_____

Have you seen any helping professionals previously for this issue/other issues?_____
What was that like?

_____

_____

_____

_____

Any diagnoses previously given to you by others:

_____

_____

_____

Do you believe that diagnosis accurately describes your experience? _____
Why or why not?

_____

_____

_____

What are your expectations/goals/hopes for this counseling experience?

_____

_____

_____

_____

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Policies and Procedures

Fees

This therapist does not accept insurance and is happy to talk to you about reasons why using your insurance for mental health services is not always the best option. In an effort to make services accessible to everyone, this office operates on a Sliding Fee Schedule as follows:

Full Fee (50 minute session) - $110;
annual income total $56K& up for single earner; $101K & up for dual earner household
Reduced Fee (50 minute session) - $85;
annual income total $46-55K single/$76-100K dual earner household
Lowest Fee (50 minute session) - $55;
annual income less than $45K single/$75K two earner household

Fees are due at time of service.

Cancellations and Reschedules

There is no fee for cancellations made with at least 48 hours notice. There is a $45 fee for a late cancellation within the 48 hour window - exceptions will occasionally be made for sudden illness or if it is possible to reschedule your appointment within the same 24 hour period. No shows (not showing for your appointment with no communication of a need to reschedule) are charged the full appointment fee. New appointments will not be scheduled while outstanding charges remain on your account. *If you need to reschedule an appointment, leave a message on your therapist's voicemail.*

Court Fees

In general, this therapist does not provide court services. If you need someone to testify on your behalf, hiring a forensic psychologist is a better match. If for any reason, this therapist is properly subpoenaed to court concerning your interactions in counseling, you agree to be responsible for and make full payment of the following fees:
$200/hour for file review, document preparation, travel time, depositions, and testimony (3 hour minimum).

Responsibilities of Client and Counselor

As your counselor, I will:

- respect you as the person most knowledgable about your situation
- treat you with dignity
- be direct & straightforward in discussing your concerns
- answer any questions you have about the process of counseling
- be on time for your appointments
- let you know in advance if it becomes necessary to reschedule (exception being if I wake up with an illness and have to cancel that day's appointments)
- abide by confidentiality guidelines as outlined above and by HIPAA
- refer you to other therapy resources in the community if I can not meet your therapeutic needs

As a client, I expect you to:

- attend appointments on time and consistently
- to be straightforward in talking to me about your concerns
- tell the truth about your situation or your history
- to complete any homework assignments given, to the best of your ability
- to sign any Release of Information Consents when necessary to communicate with other health care providers, in order to provide best care

I agree to pay fees at time of service. I understand I must give 48 hours to reschedule an appointment outside of an emergency or sudden illness. I agree with the Client/Counselor responsibilities above.

_____ _____

Client: Signature **Date**

_____ _____

Client: Print Name **Date**

_____ _____

Guardian: Signature **Date**

_____ _____

Guardian: Print Name **Date**

Informed Consent

LPCA Professional Disclosure Statement

Jennifer L. Coleman

Qualifications

Jennifer Coleman received a Masters of Science degree and an Educational Specialist degree in Community Counseling and Marriage and Family Counseling respectively, from the University of North Carolina at Greensboro in 2004. She is a Licensed Professional Counselor Associate (#13880) with over a decade of counseling experience in various settings. Jennifer currently receives Supervision from Isis Reddick-Umoja, LPCS (#5341).

Counseling Background

Jennifer has worked with couples, families, and individuals from age 15 to older adults, successfully addressing challenges such as depression, anxiety, grief, anger, relationship issues, and life transitions. She is influenced in her work by the ideas and techniques of solution-focused therapy, narrative therapy, and motivational interviewing. She believes that every person is capable of re-ordering their lives, of re-telling their own past in a way that makes sense to them, and determining the terms of their future.

Session Fees and Length of Service

Counseling sessions are generally 45-50 minutes in length, except for the initial session that is 55-60 minutes. Fees are outlined in the Policies & Procedures section above. Cash and credit cards are accepted and payment is accepted at the time service is rendered. A receipt with required information will be provided, upon request, for you to submit to your insurance company if you choose to file out of network. If you are utilizing the Sliding Fee Scale for payment (rather than full fee), the agreed upon fee is indicated here $_____.

Use of Diagnosis

This therapist does not file insurance. If you choose to file insurance yourself, out of network, please be aware of the following: Most health insurance companies will require that a diagnosis of a mental-health condition is made and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which

people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before you submit the diagnosis to the health insurance company. *Please be aware* that any diagnosis made will become part of your permanent insurance records.

Confidentiality

What you disclose to your counselor within a session is confidential. This information will not be shared with anyone without your permission, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse) or in danger from abuse yourself, or (c) I am ordered by a court to disclose information. If any of these exceptions to the standards of confidentiality should occur, you will be informed of the counselor's duty to share and to whom the information will be disclosed.

Complaints

Although clients are encouraged to discuss any concerns with me, if I fail to address your concerns adequately, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblpc.org

Acceptance of Terms

We agree to these terms and will abide by these guidelines.

Client: _____ Date: _____

Counselor: _____ Date: _____

Guardian: _____ Date:_____

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HIPAA Signature Page

You have the right to receive notice of any changes that may occur to these privacy practices, your client rights, and the legal duties of Jennifer Coleman, LPCA that affect the use and disclosure or your protected healthcare information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
By signing below, you acknowledge that you have been provided a copy of the HIPAA Notice of Privacy Practices.

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian Date

The Notice explains how your healthcare information can be used and disclosed and how you can access that information. You are encouraged to read it. If you have any questions please feel free to ask before signing.

In regards to contacting you regarding appointments or other matters related to counseling, you have chosen to be contacted at: _____
Can we leave a message at this number?

- Home
- Work
- Cell phone
- Email
- If other, how may we contact you:_____

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian Date