Hicks Counseling Services

Beverly Hicks, M.Ed., LPC
2301 Stonehenge Dr. Ste. 202 Raleigh, NC 27615
Office: 919.904.4257 hickcounseling@gmail.com Fax: 866.594.1848

General Information Form

Last Name _____ First _____ MI ___ Nickname _____ Sex: M F

SS# _____ DOB _____ Home# _____ Cell# _____

Street _____ City _____ State ___ Zip _____

Home# _____ Cell # _____ Contact Person's Email _____

Married __ Single __ Separated __ Divorced __ Widowed __ Under 18 years of age? Yes ___ No ___

If under 18… Mother's Name _____ Cell _____ Father's Name _____ Cell _____

Current Medications _____

Name of Responsible Party Covering Deductibles and Co-pays _____

Same address as above? Yes __ No __

Street _____ City _____ State ___ Zip _____

Primary Care Physician's Name _____ Phone _____

PRIMARY Insurance Coverage - PLEASE DO NOT LEAVE ANY BLANKS

Insurance Co. _____ Managed Care Co. _____ Tel# _____

Claims: Street _____ City _____ State ___ Zip _____

Policy# _____ Group# _____

**Please present your card to therapist to be photocopied

MENTAL HEALTH Insurance Coverage- PLEASE DO NOT LEAVE ANY BLANKS

Insurance Co. _____ Managed Care Co. _____ Tel# _____

Claims: Street _____ City _____ State ___ Zip _____

Policy# _____ Group# _____

Is precertification necessary? If Yes, Authorization #_____ # of visits _____ Start ____ End _____

Name of Policyholder _____ (Must match to policy# above) Relationship to client _____

Address of Policyholder _____City _____State ____Zip _____

Policyholder's Date of Birth _____ (required) Home # _____Work# _____

Social Security # of Policyholder (required if different than above) _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage stated above and assign payment directly to entity named above all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor/therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance. I am entitled to a copy of this agreement by requesting one.

_____ _____ _____

Responsible Party Signature **Relationship** **Date**

Beverly J. Millican-Hicks, M.Ed., L.P.C.

Phone: 919-904-4257 Fax: 866-594-1848

2301 Stonehenge Dr. Ste. 202 • Raleigh, North Carolina 27615 • www.HicksCounseling.com

Professional Disclosure

I believe the counseling experience is one in which there is a personal relationship based on trust within a safe and confidential environment. This document is part of the standards of practice of the North Carolina Board of Licensed Professional Counselors. Please read this statement prior to our first session.

Education & Experience:

I have a Masters in Education from Southern Methodist University in Dallas, TX. My area of special interest and experience is working with couples in marriage counseling and individuals who have been abused or have experienced other traumatic events, as well as individuals suffering from mood and personality disorders. My experience includes working with individuals, families, couples, addictions, high risk youth, chemically dependent individuals and their families, the dually diagnosed, as well as the geriatric population.

I am a Licensed Professional Counselor (LPC # 2874) with the North Carolina Board of Licensed Professional Counselors. In addition, I am a Certified Clinical Supervisor (CCS #176) as well as a Certified Substance Abuse Counselor (#1013) with the North Carolina Substance Abuse Professional Certification Board. I am a Licensed Marriage and Family Therapist (LMFT, TX #003662-003801) and a Licensed Chemical Dependency Counselor (LCDC, TX #3377).

I also hold memberships with the North Carolina Counselors Association, the Licensed Professional Counselors Association of NC, NC Association of Student Assistance Professionals, Texas Association of Alcohol and Drug Abuse Counselors and the National Association of Alcoholism and Drug Abuse Counselors.

Counseling Philosophy:

The purpose of counseling is to help individuals, couples and families resolve issues that are interfering with the enjoyment of the process of life. You may want to resolve specific problems or bring a more positive balance to your life. Whether it is individual, couple, family or group counseling, we will initially determine your goals and assess if we can work together to meet them. As counseling continues, we will regularly evaluate our progress to determine if your goals have been met or if there is a need for additional sessions, termination, or a referral to another practitioner for counseling or assistance.

Counseling sessions will be held within the counseling office only. For your best interests and to protect your personal rights, our relationship must remain professional at all times; this means that even though our relationship may seem very intimate, you must remember that I am only sharing with you as a professional and focusing on the goals you have indicated you desire to reach. This is the primary purpose of our relationship.

Fees and Insurance Reimbursement:

My fees are $160 for your initial visit and $145 per 45-50 minute follow-up visit. All payments are due at the time of service. I accept cash, checks or credit/debit card. If you are unable to come with your child to attend therapy please send them with the appropriate payment. Clients are responsible for

contacting their insurance company to obtain authorization, co-pay, deductible and benefit period information.

Please be aware that any personal information or diagnosis provided to an insurance company can no longer be held to the same standard of confidentiality, and may well become part of your permanent insurance record. Appointment cancellation must be made at least 48 hours in advance to avoid being charged a missed appointment fee of $60.

Confidentiality:

All information shared will be kept confidential with the following exceptions.

1) If I believe you are a danger to yourself or someone else
2) In case of abuse to a child or an elderly person confidentiality will be waived
3) If you give me written permission to disclose information
4) If the information is court ordered
5) In case of a medical emergency
6) If you desire to seek reimbursement from a managed care company, the disclosure of confidential information may be required for reimbursement
7) If accusations of misconduct are brought

I also understand and agree that for the purpose of ensuring highest quality care and with my agreement, my case may be discussed in conference or supervision with other psychologists or mental health professionals. If I should default in paying the balance of my account with HCS, then I understand that identifying information and dates of service may be disclosed if litigation or collection action becomes necessary.

Emergencies:

In a medical emergency please call 911. Hicks Counseling Services uses a confidential voice mail system. Even with a good communication system, there may be circumstances under which I cannot immediately respond to a client's needs. If such an urgent situation arises please contact Holly Hill Hospital Respond program to obtain the support of their counselors. The Holly Hill Respond telephone number is 919-250-7000.

Complaints:

If, at any time, you feel my behavior or my counseling approach is inappropriate or troubling to you, please let me know. If, however, you do not feel your concerns are being addressed appropriately, feel free to contact any or all of the following:

North Carolina Board of Licensed Professional Counselors
PO 77819
Greensboro, NC 27417
Phone: (844) 622-3572 or (336) 217-6007 Fax: (919) 779-5642
E-mail: Complaints@ncblpc.org

The North Carolina Substance Abuse Professional Certification Board
PO Box 10126
Raleigh, NC 27605
(919) 832-0975 Fax: (919) 833-5743

Client Responsibilities:

As a client you have the responsibility to set and keep appointments. Let me know as soon as possible, at least within 48 hours, if you cannot keep an appointment. Pay your fees in accordance with the schedule you pre-established with the counselor. Help plan your treatment goals and follow through with agreed upon goals. The client is responsible for his/her actions when he/she refuses treatment or does not follow the practitioner's instructions. The client is responsible for following the facility's rules and regulations affecting client care and conduct. The client is responsible for being considerate of the rights of other clients and facility personnel. The client is responsible for holding in strict confidence other client's mental health/substance abuse information which may be obtained during group therapy and socialization. It is also your responsibility to keep your counselor informed of your progress towards meeting your goals and to terminate your counseling relationship before entering into arrangement with another counselor.

Please list any questions you have and bring them with you to your first visit. I will be sure to address all of your questions and concerns.

Consent for Treatment:

By signing below, you indicate that you have read this disclosure, that your questions have been answered and that you understand the above information. Your signature also indicates that you are consenting to receive counseling services.

Acknowledgement of Notice of Privacy Practices:

My signature indicates that I have received a copy of the HIPAA Notice of Privacy Practice and had an opportunity to ask any questions I may have.

Client Rights, Responsibility and Confidentiality:

My signature attests that I have read, and fully understand my rights as a client, as well as my responsibilities. Additionally I am aware of the limits of confidentiality.

_____ _____

Client Signature Date

_____ _____

2nd Client Signature or Parent/Guardian Signature Date

_____ _____

Witness Signature Date

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Service Agreement

Scope of Confidentiality: I understand that my disclosures to the staff of Hicks Counseling Services (HCS) will not be revealed to outside parties except in the following instances: 1) Where my written permission has been granted; 2) Where my physical safety or the physical safety of another person is threatened; 3) Where evidence is given of physical or sexual abuse; 4) Where records are subpoenaed by a judge. I also understand and agree that for the purpose of ensuring highest quality care, with my agreement my case may be discussed in conference or supervision with other psychologists or mental health professionals. If I should default in paying the balance of my account with HCS, then I understand that identifying information and dates of service may be disclosed if litigation or collection action becomes necessary.

Emergencies: Hicks Counseling Services uses a confidential voice mail system. However, even with a good communication system, I understand that there may be circumstances under which my therapist cannot immediately respond to my needs. If such an urgent situation arises I agree to contact the Holly Hill Hospital Respond program to obtain the support of their counselors. The Holly Hill Respond telephone number is 919-250-7000.

Authorization for Release of Psychological/Treatment Information: HCS is hereby authorized to release treatment/psychological/assessment information to my insurance carrier/HMO/PPG as required by them to determine the appropriateness of care and/or to guard against fraud and as stated in their published policies and procedures.

Assignment of Insurance Benefits: I hereby authorize payment directly to HCS of insurance benefits for provided services otherwise payable to me.

Responsibility for Payment: I agree that I am responsible for the total balance due on my account for all services rendered by HCS even though I may arrange for my healthcare plan to pay for part of it. I agree to allow HCS to use any credit card information that I provide for paying off unpaid balances on my bill. I also agree to pay a charge of $35 dollars for each occurrence of insufficient funds for an attempted check. It is my responsibility to inform HCS of my current address until my balance is paid in full.

Co-Payments: Co-payments are due at the time service is rendered unless other arrangements are made. Check, credit or debit cards are accepted.

Missed appointments, Late Cancellations, and Other Non-Co-Payment Charges: Because I will reserve appointment times in advance at HCS, I also agree to pay $75 for any scheduled appointments that I miss without advance notice. I understand that advance notice is no less than 2 BUSINESS days.

Hicks Counseling Services

Service Agreement Continued

If you Choose to Have Your Insurance Pay Directly: It is the policy of HCS to obtain security in the form of your credit card authorization to conveniently pay possible charges that will not be covered by your insurance carrier. These charges can include unanticipated missed appointments/late cancellations, charges for insufficient funds for check or credit card payments, unanticipated deductibles, insurance company payment discrepancies from actual fees, and changes in copayment rate and other changes that insurance plans sometimes make when contracts are renewed. Regular co-payments do not cover these charges. Whenever missed appointments, late cancellations, or insurance non-payments occur, your credit card will be charged the applicable amount and you will be notified. Regular co-payments will be made at each session and you will be able to choose your method of payment at that time.

Outstanding Balances: Any outstanding balances past 90 days will be charged in full to the credit card on file. Failure of payment will result in discontinued services with HCS.

Today's Date: _____

Name on Card: _____

Card #: _____

Card Type: _____

Expiration Date: _____

Billing Street Address: _____

Billing Zip: _____

Client Name: _____

Signature: _____

_____ By checking here, I, the patient, am stating that I fully understand and accept the terms of this consent hereby agreeing to substitute this checked box as my signature.

_____ By checking here, I, the responsible party, am stating that I fully understand and accept the terms of this consent hereby agreeing to substitute this checked box as my signature.

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FEE SCHEDULE

All co-pays and out-of-pocket payments must be paid at the time of service. If you are unable to come with your child to attend therapy please send them with the appropriate payment.

Clients are responsible for contacting their insurance company to obtain authorization, co-pay, deductible and benefit period information. Please provide this information with a copy of the front and back of your insurance card by faxing it to (866) 594-1848 or bring it at the time of your visit. If you have questions regarding in-network or out-of-network outpatient mental health benefits, please call your insurance company.

For your convenience, we accept MasterCard, Visa, Discover or checks.

Initial Evaluation	$160
Individual Psychotherapy	$145
Family /Conjoint Psychotherapy	$145
Support Group	$60
Life Coaching	$100
Legal Services	$500/hour* Plus $150/day for being on-call for court consultation.
Form Completion/Letter Writing	$160/hour**
Phone Consultation	$40/15 min. increments***
Supervision	$100/hour

*Legal Services are NOT performed unless required by subpoena. Court appearances, depositions, phone calls with attorneys and records required are included in this fee. This service is not billable to your insurance company and must be paid out of pocket before services are rendered.

**This includes recommendation letters, forms for schools, disability forms, and letters to employers. This service is not billable to your insurance company and must be paid out of pocket.

***In special situations clients may schedule a phone session or consultation. These situations are billed as a regular psychotherapy session and are billed to insurance. Out-of-pocket phone consultation fees apply when the client does not have a scheduled phone session but requests a phone call on ANY topic other than appointment scheduling. Such time is not billable to your insurance company.

If you are unable to attend your scheduled session and do not cancel within the 2-business day cancellation period you will be charged $75 which is NOT billable to your insurance company. Please sign below indicating you have read and agree to pay the above fees for services.

Printed Name: _____

Signature: _____ Date: _____

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HIPPA NOTICE OF PRIVACY PRACTICES

PROTECTED HEALTH INFORMATION (PHI)

A. PHI is information that is created in the process of assessment and treatment and contains identifying information. It contains data about health conditions, past and present, services provided and payment information.

B. Law requires that this information is protected and Notice I provided as to when, how, and why PHI may be used within the practice and/or disclosed to a third party. Only necessary information is used or disclosed. If these policies change, this Notice shall be updated and posted; changes retroactive to beginning date of service.

WHEN, HOW, AND WHY PHI MAY BE USED/DISCLOSED

A. Prior Written Consent is Not Needed for Disclosure or Use Related to Treatment, Payment of Health Care Operations

1. Treatment, sharing information with health care providers involved in your care does not require written consent.
2. Health care Operations. PHI may be used to facilitate correct operation of the practice (i.e. accounting, legal, and consulting services used by the practice.)
3. Payment Billing and Collection services that require use and/or disclosure of PHI, such as billing the insurance company do not require prior consent.
4. Other Disclosures.
    - Emergencies.
    - Dangerousness. Mental status indicates danger to self, others, or property of others.
    - Contact client for appointment reminders, benefits and services of interest
    - Legally required by subpoena or court-order to release PHI
    - Abuse/Neglect suspected of child, Disabled or Elderly

B. Prior Written Consent is Required for Use and Disclosure of PHI in Other Circumstances

1. Family, friends or others-PHI may be shared in coordinating treatment or payment unless you object in part or in whole. You may revoke consent at any time. Emergencies may cover use of information as listed I-A4
2. Other Situations-In any other situation not described in previous sections, written authorization will be required before using or disclosing your PHI. You may revoke consent at any time and limit information to be released.

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HIPPA Notice of Privacy Practices Continued

YOUR RIGHTS

A. The Right to See and Get Copies of Your PHI.
   1. Must be requested in writing and response given within 30 days of receipt of request. If denied, a written explanation will be provided and can be appealed. There will be a charge of $0.25 per page. Summaries and Reports requested will also require a charge to be determined upon request.

B. The Right To Request Limits on Uses and Disclosures of Your PHI.

C. The Right to Get a List of Disclosures Made.
   1. Accounting of Disclosures Log is available at no cost (one copy/year), but will not include disclosures for treatment, payment or operations.

D. The Right to Amend Your PHI. If you believe an error or omission of importance exists in your PHI, request made in writing will be addressed within 60 days of receipt. Denials will be made in writing with an explanation as to why and how you can challenge the denial. And your request may be included in the PHI Denials would occur if the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone else.

E. The Right of a Copy of the Notice.

HOW TO COMPLAIN ABOUT PRIVACY PRACTICES

If you feel your rights have been violated or you have an objection, you may file a complaint with me or you may send a written complaint to the Secretary of the Department of Health and Human Services.

EFFECTIVE DATE OF NOTICE HIPPA

Notice of Privacy Practices effective April 14, 2003

I fully understand and accept/decline the terms of this consent.

Today's Date: _____

Clients Name (printed): _____

Signature of Client or Responsible Party: Name: _____

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Authorization for Release of Information or Records

Client Name (please print): _____DOB: _____

Authorized Representative-if different from client (please print): _____

Contact Phone: _____ Email: _____

I hereby give permission for Beverly Hicks, M.Ed., LPC to disclose clinical information and/or obtain information from:

__ Family member __ Doctor __ Lawyer __ Hospital __ School __ Other: _____

Contact Name: _____ Phone: _____ Address_____

City, State: _____ Zip: _____

__ Family member __ Doctor __ Lawyer __ Hospital __ School __ Other: _____

Contact Name: _____ Phone: _____ Address_____

City, State: _____ Zip: _____

__ Family member __ Doctor __ Lawyer __ Hospital __ School __ Other: _____

Contact Name: _____ Phone: _____ Address_____

City, State: _____ Zip: _____

I am authorizing the following information to be released (please check only the area you want information release):

____ Scheduling and/or billing purposes

____ Phone Consultation (preferred)

____ Attendance record only

____ Diagnosis and assessment only

____ Progress report on treatment

____ Treatment recommendations only

____ Other (specify)

_____

I may revoke this consent at any time with a written request. This authorization will expire one year after the date of this document.

Signature: _____ Date: _____

(client or authorized representative (parent of guardian)

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