Haven of Rest Counseling, PLLC
103 W South Railroad Street
Four Oaks NC 27524
(919) 631 2483 (Phone) (919) 882-1802 (fax)

# Intake Form

***PLEASE PRINT CLEARLY*** Today's Date _____

## PERSONAL INFORMATION

**PATIENT (S)** _____ **RESPONSIBLE PARTY** _____

Date of Birth _____ Gender _____ Responsible Party's SSN _____

Address _____ Address (if different) _____

_____ _____

City, State _____ Zip _____ City, State _____ Zip _____

Home Phone _____ Home Phone (if different) _____

Work Phone _____ Work Phone (if different) _____

Cell Phone _____ Cell Phone (if different) _____

***Please indicate with an * which phone numbers we may NOT leave a message.***

Patients' relationship to Responsible Party (check one): Self_____ Spouse_____ Child_____ Other _____

Relative or friend in case of emergency _____

Name Phone # Relationship

Name

Phone # Relationship

Source of referral _____ Reason for referral _____

How did you hear about Haven of Rest Counseling, PLLC? _____

## FINANCIAL

Haven of Rest Counseling, PLLC accepts and files insurance. I understand I am responsible for any amount the insurance company does not cover. As well, I understand that if I cancel within 24 hours or do not show up for an appointment I will be billed the entire amount of the session. I have been given the opportunity to ask questions regarding this statement.

_____ _____ _____

Signature of Responsible Party Printed Name Date

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## FAMILY INFORMATION

| NAME | M/F | AGE | DATE OF BIRTH | RELATIONSHIP TO PATIENT &/or MARITAL STATUS | EDUCATION | OCCUPATION |
|---|---|---|---|---|---|---|
| **Patient (s)** | | | | | | |
| **1.** | | | | | | |
| **2.** | | | | | | |
| **Parent (s)** | | | | | | |
| **1.** | | | | | | |
| **2.** | | | | | | |
| **Children/Step Children/Siblings** | | | | | | |
| **1.** | | | | | | |
| **2.** | | | | | | |
| **3.** | | | | | | |
| **4.** | | | | | | |
| **5.** | | | | | | |
| **6.** | | | | | | |
| **Others Living in Household** | | | | | | |
| **1.** | | | | | | |
| **2.** | | | | | | |
| **3.** | | | | | | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| **4.** | | | | | | |
| **5.** | | | | | | |
| **6.** | | | | | | |

## MEDICAL INFORMATION

1. **Patient Name _____**

   Have you ever been treated for emotional difficulties before (When and Where?) _____

   _____

   Physician: Name/Practice _____ Address_____ Phone _____

   Date of last physical exam _____ Height _____ Weight _____

   How is your general health now? _____ Medications? _____

   Are you presently being treated by a physician for any physical condition? _____

   Have you had any serious illness? (List) _____

   Have you ever had any surgery? (List) _____

2. **Patient Name _____**

   Have you ever been treated for emotional difficulties before (When and Where?) _____

   _____

   Physician: Name/Practice _____ Address_____ Phone _____

   Date of last physical exam _____ Height _____ Weight _____

   How is your general health now? _____ Medications? _____

   Are you presently being treated by a physician for any physical condition? _____

   Have you had any serious illness? (List) _____

   Have you ever had any surgery? (List) _____

***If more than two patients, please indicate above medical information on separate sheet for other patients.**

**PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)**

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| | | |
|---|---|---|
| ___Anger | ___Grief | ___Paranoia |
| ___Anxiety | ___Guilt | ___Physical Aggression |
| ___Behavior Problems | ___Hallucinations | ___School/Work Problems |
| ___Changes in Appetite/Eating Habits | ___Hopelessness | ___Self Abusive Behavior |
| ___Criminal Activity | ___Hyperactivity | ___Sleep Disturbance |
| ___Decreased Energy | ___Impulsiveness | ___Somatic Complaints |
| ___Delusions | ___Interpersonal Conflicts | ___Suicidal Thoughts/Attempt |
| ___Depressed Mood | ___Irritability | ___Weight Gain |
| ___Disruption of Thought Process/Content | ___Manic | ___Weight Loss |
| ___Emotional/Physical/Sexual Trauma | ___Mood Swings | ___Worthlessness |
| ___Excessive Crying | ___Oppositional | ___Other (Specify) |
| ___Family Conflicts | ___Panic Attacks | |

How could your life be better?

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and licensed/certified therapist. We wish to take this opportunity to welcome you and to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
   a) Type of therapy needed (individual, group, medication referral, etc.)
   b) Frequency of therapy sessions (weekly, biweekly, etc.)
   c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment is approximately 60 minutes. At the end of each appointment you can discuss future appointments with your therapist.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

4. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. If you do not pay in full at the time of service. Charges for services in addition to therapy may be levied (i.e., involvement in client litigation, document preparation, etc.). These fees will be negotiated individually with your therapist. We accept cash and check.

5. INSURANCE: Haven of Rest Counseling, PLLC is paneled with numerous insurances and EAP Companies. I am willing to verify your coverage for services or you can contact your insurance company and verify. You are responsible at the time of each visit to pay your co pay and any outstanding charges that your insurance company has not satisfied. Please know that your insurance company will require a diagnosis before they will pay for services.

6. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at Haven of Rest Counseling, PLLC via Electronic Health Records and is considered confidential within the office unless specified by you

in writing. However, each therapist at this office reserves the right to use specialty consultation with other therapists at the office as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

*If more than one adult patient, each person should check and initial boxes.*

☐ Yes ☐ No I acknowledge that I have read and understand all the foregoing statements and that my signature below indicates that I agree to abide by all the above conditions.

☐ Yes ☐ No I have received a copy of the Privacy Practices Form.

☐ Yes ☐ No I consent to the exchange of treatment information between Haven of Rest Counseling, PLLC and my primary care physician.

Patient(s):

Physician's Name/Office and Phone Number _____

Signed: _____ Date: _____

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## Privacy Practices Form

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Patient(s):

Physician's Name/Office and Phone Number _____

**CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS**

## Consumer Rights Information

In the state of North Carolina, basic human rights are defined to be the right to dignity, privacy and humane care. In addition to these basic human rights, when you are receiving publicly funded MH/IDD/SA services, you have the right to:

- Privacy and the expectation that your personal information will be kept confidential;
- Review your medical record;
- Receive care in the least restrictive environment suitable to meet your needs;
- Be informed in advance of potential risks and benefits of treatment or habilitation services, and to consent to or refuse these services;
- Participate in the development of an individualized, person-centered treatment or service plan
- Be free from mental and physical abuse, neglect and exploitation;
- Be free from unwarranted invasion of privacy;
- Be free from the threat or fear of unwarranted suspension or expulsion from services;
- Fill out an Advanced Directive, which describes how you want to be cared for if you are ever unable to decide or speak for yourself;
- Access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability
- File a complaint or grievance.

Please bring any concerns to my attention so that I may work with you to resolve them. I will respond to any grievances within 5 business days. But if you have concerns that we cannot resolve together, you may file a grievance with the offices below:

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Advocacy & Customer Service Section - Division of MH/DD/SAS
3009 Mail Service Center Raleigh, NC 27699-3009
919-715-3197 OR 800-662-7030
www.dhhs.gov/mhddsas
Disability Rights North Carolina
2626 Glenwood Avenue, Suite 550
Raleigh, NC 27608
877-235-4210 OR 919-856-2195
www.disabilityrightsnc.org

Client Signature:_____Date:_____

**I give Haven of Rest Counseling PLLC permission to contact me concerning my appointments:**

**Text to number: _____**

**E-mail to address: _____**

**Preferred method of contact is:**

**Text ☐**
**E-mail ☐**

**Client Signature:_____Date:_____**

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