CAROLINA FAMILY SERVICES, LLC

IMPROVING-INSPIRING-STRENGTHENING-EMPOWERING

New Client Intake Packet

17 Memorial Medical Drive Greenville, SC 29605
115 F Southport Road Spartanburg, SC 29306
(864) 283 – 0637 Phone (864) 283 – 0638 Fax

Full Legal Name: _____ Nickname: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____ Phone Number: _____

SS# _____ Gender: _____ Race: _____ Date of Birth: _____

Marital Status: _____ Email address: _____

Mother's Name: _____ Father's Name: _____

Legal Guardian's Name: _____ Group/Facility Name: _____

Who do we call in the event of an emergency? _____

Referral Source: _____
Case Manager, Agency Name, Phone Number

Primary Care Physician: _____

GUARANTOR INFORMATION

(Person Financially Responsible for Any Patient Balances)

Name: _____ Date of Birth: _____ Sex: _____

Mailing Address: _____ SSN: _____

Relationship to Patient: _____ Employer: _____

Home Phone: _____ Cell: _____ Work: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Primary ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Insured's Relationship to the client: _____

Secondary Insurance Company: _____ Secondary ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Insured's Relationship to the client: _____

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I certify that I, and/or my dependent(s) have coverage with _____ and _____ (if applicable) and assign directly to Carolina Family Services of Greenville, LLC all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment has ended or has been terminated by Carolina Family Services of Greenville, LLC.

_____ _____ _____

Client/Guardian Signature | Relationship to Client | Date

PLEASE INDICATE YOUR PREFERRED METHOND OF CONTACT & HIPAA RELEASE OF INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Carolina Family Services of Greenville, LLC?

[ ] Any Method of Contact

Only Via The Following Method(s):

[ ] Home Telephone
[ ] Cell Phone
[ ] Work Phone
[ ] Email: _____

May we leave a message on your answering machine?

[ ] Yes
[ ] No

Can we text you regarding upcoming appointments and other clinical issues regarding treatment?

[ ] Yes This is the number I accept texts to and understand this is not HIPAA protected: _____
[ ] No

UPDATED POLICY (Effective February 2020):

Children under the age of 18 MUST be supervised at ALL times by a parent, guardian or agency representative. Carolina Family Services' Staff and its entities are not responsible for the safety, care, supervision or entertainment of ANY child left unattended. While we understand that parent participation is important in therapy, it is YOUR responsibility to ensure childcare for children who accompany patients to Carolina Family Services. In addition, at no time, should a child be left in the lobby while a guardian leaves the building or its facilities.

Failure to respect or abide by this policy may result in immediate termination and discharge from Carolina Family Services.

Please sign below that you are aware of this policy and agree to abide by this at ALL times.

Signature: _____ Date: _____

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NOTICE OF PROCEDURES NOT COVERED UNDER HEALTH INSURANCE

(INCLUDING MEDICAID ALL PRIVATE INSURANCE PROVIDERS)

Insurance coverage of Mental Health services is not a guarantee of payment for services. It is the responsibility of the patient to pay for any services not covered under their insurance plan. Payment is required upon services rendered unless the patient has made prior arrangements with CFSOGLLC. Your signature below acknowledges that you understand the "Payment of Procedures Not Covered" policy, and that you understand you may be responsible for payment of ALL services rendered.

Guarantor (Person Responsible) Name: _____

PLEASE PRINT

Drivers License #: _____ State Issued: _____

Signature: _____ Date:_____

Witness Signature:_____ Date:_____

ACKNOWLEDGMENT OF "NO SHOW FEE" POLICY

This policy has been established in order to provide the highest level of Mental Health Therapy Services to all of our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us notice of a cancellation, we may be able to accommodate other patients with your appointment slot. We kindly ask that you call at least 24-hours prior to your scheduled time, when you knowingly are unable to make your appointment. Cancellations within 24-hours of your appointment will be considered a late cancellation and will be noted on your record. After two (2) no shows/late cancellations, the patient will be discharged from treatment and the following will occur: a letter will be sent to your last known address discharging you from treatment, and all future therapy and medication management & therapy appointments will be removed from our schedule. Once you have been discharged from treatment, your case will be closed for (6) months and will NOT be reopened prior to the date we determined that your were eligible for discharge.

We do understand that emergencies arise and that it may not be possible to give such a notice. Exceptions to the No-Show/Late Cancellation Policy will be determined on a case by case basis and only when no more than (3) appointments have been missed within a (6) month time frame.

Print Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

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Authorization to Disclose/Release Health Information

For Office Use Only

Full Legal Name: _____ Nickname: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____ Phone Number: _____

SS# _____ Gender: _____ Race: _____ Date of Birth: _____

** PLEASE READ BOTH PAGES OF THIS FORM BEFORE SIGNING BELOW.**

MY AUTHORIZATION:

I request and authorize the release of information FROM the following:

1. _____
2. _____
   (Please include relatives who may be involved in clinical treatment)

I give permission for Carolina Family Services to release records TO the following:

1. _____
2. _____
   (Please include relatives who may be involved in clinical treatment)

What I AUTHORIZE TO BE DISCLOSED (Please Check All That Apply):

- o Assessment and Evaluations (Diagnostic, Follow-up, CALOCUS, Psychiatric)
- o Clinical Service Notes-Therapy
- o Psychiatric Medication Management Notes
- o Treatment Plans of Care
- o Screening Assessments/Measures Used
- o Treatment Progress Summaries
- o Letters of Recommendation
- o Discharge Summary/Termination of Service Information

Please Note: This includes specific permission to release the following:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, but not limited to:

- ❖ Psychological, psychiatric or other mental impairment(s) (excludes “psychotherapy notes” unless otherwise requested or subpoenaed).
- ❖ Drug abuse, alcoholism, or other substance abuse
- ❖ Medical diagnoses, self-disclosures about medical history, or past diagnostic information.
- ❖ Sickle Cell Anemia
- ❖ Human Immunodeficiency Virus (HIV) infection, including Acquired ImmunoDeficiency Syndrome (AIDS) or tests for HIV or sexually- transmitted disease.

2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work.

3. Copies of education tests or evaluations, including individualized education programs, assessments, psychological and speech evaluations, teacher observations and evaluations, and any other records that can help evaluate my or my child's functional level.

4. Information created after this authorization is signed, as well as past information that may be pertinent to requested release.

I UNDERSTAND THAT:

- I understand that I have the right to revoke this authorization, in writing, at anytime.

- There are some circumstances where the information may be disclosed to other parties involved for the purpose of billing or by subpoena.

- I may receive a copy of this form upon request.

- I may ask the source to allow me to inspect or get a copy of the material to be disclosed by Carolina Family Services of Greenville prior to authorized disclosure.

PLEASE NOTE: Randomly selected records are read by licensing personnel, insurance auditors and peer reviewers for accrediting bodies. Detailed information, including name, age, mental health diagnoses, and reasons for admission, purpose of treatment, etc, may also be reported or disclosed to South Carolina Department of Health and Human Services. If you are concerned that your information will be disclosed or want to know if your information has been disclosed, then you have the right to request this information.

Legal Guardian Signature: _____ Date: _____
(if under 18)
Legal Guardian Name: _____ Relationship: _____
(Please Print)

Client/Patient Signature: _____ Date: _____

Client Name Printed: _____

Witness Signature: _____Date: _____

Witness Name Printed: _____ Relationship: _____

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CAROLINA FAMILY SERVICES OF GREENVILLE PROFESSIONAL DISCLOSURE AND CONSENT FOR TREATMENT

The majority of this document is mandated by both South Carolina State law and Public Law 104-191 and is provided for your protection. Carolina Family Services of Greenville LLC (CFSOG) has tried to anticipate any risks you may face as a result of being in therapy. If you have any questions regarding the documents you have received, please feel free to discuss them during your intake session.

Contact Information: CFSOG has two physical locations: 17 Memorial Medical Drive Greenville, SC 29605 and 115 F Southport Road Spartanburg SC 29303. The Greenville location is our primary mailing address. Our office hours at the Greenville location are Monday-Thursday 8:30am-8:00pm. Our telephone number is 864-283-0637, and we have a confidential voicemail. You can also reach us by fax at (864) 283-0638. At our Spartanburg location, we are currently open Monday-Thursday 8:30am-8:00pm. Any calls placed on Friday or over the weekend will return when normal hours resume on Monday. Our email address is **info@carolinafamily.org,** and it is checked at least once every day. Our website is www.carolinafamily.org and contains more information regarding Carolina Family Services, and all of the services that we provide

Therapist Information: All of our therapists are licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage, and Family Therapists, and Psycho-educational Specialists.

This Board is located in The Synergy Center (Kingstree Building) in Columbia, South Carolina at 803-896-4652 (mailing address is P.O. Box 11329 Columbia, SC 29211-1329). All of our therapist abide by the American Counseling Association Code of Ethics which can be found in its entirety by following this link: https://www.llr.sc.gov/POL/Counselors/PDFS/Code_Ethics_Counselors.pdf. The Code of Ethics is summarized in the remainder of this document. We employ a variety of therapists with a range of experiences and expertise. During your first session with your therapist, they will provide you with a statement detailing their education, training, licensure limits, and clinical experiences. However, please note that there are two Licensed Professional Counselor Supervisors on staff, and your child's case may be discussed in supervision. In the event that you have a problem with the therapist rendering services to your child, please contact the Supervisor listed below who is directly responsible for the supervision of that therapist at (864) 283-0637 or by their respective emails at ***Jennifer@Carolinafamily.org*** or ***Tamara@carolinafamily.org.***

Jennifer Brooks, LPCS Ph.D	Tamara Siders, MA, LPCS, NCC	Katina Jones, MA, LISW-CP
Amanda Hock	Christopher Bradt	Terrance Dawkins
Sarah Fuller	Houda Nizam	
Taylor Des Marias	Sarah Van Wyk	
	Juliana Wade	

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We also have the following fully licensed therapist on staff:

Melinda Tyson, MS, LPC	Roger Rhoades, LPC	Lucilla Beaton, LMSW, LISW-CP
Lindsay Oswald, ED.S, LPC	Sarah Olma, M.ED, LPC	Nitoya Evans, MA, LPCS
Kevin Mallory, MS, LPCS		

Each respective therapist is expected to provide you with an individualized professional disclosure statement.

For us to consider providing services to you, you must read and sign this consent form. You may withdraw this consent to treatment at any time in writing and ask that your file be closed. You should also know that this is not an agreement with CFSOG to provide services to you. You may wish to talk with your therapist about your consent to treatment during intake session. He/she will answer your questions to your satisfaction.

Understanding Psychotherapy: Psychotherapy and psychiatric services are designed to help you or your child change. Sometimes this kind of change is difficult because it raises feelings, thoughts, and worries that people try to keep inside. The benefits of therapy to you *or* your child may include improved behavior, relationships and mood. S/he may learn to communicate better with you and with others. You should know that this is not a precise science. In many cases we are successful in helping people to change and in some cases we are not, which is always a risk with treatment. CFSOG cannot guarantee the success of any treatment. As a parent your involvement in your child's therapy is very important. We adamantly believe that change in a child involves a change in the family. This is why we often ask parents, guardians, grandparents and other family members to participate in the treatment process. This shows support for your child and your interest in helping him or her. It can also help you to handle problems with your child and understand him or her better. Many parents find they can learn new ways of dealing with their families and children through therapy.

Confidentiality: For therapy to be effective, child and adolescent clients must feel they are able to speak freely without consequence of disclosure to their parents or authorities who are bringing the for treatment. Thus, all services provided are strictly confidential. We cannot release any information about your child to anyone outside CFSOG without your written consent. In order to help your child and family we do share information between staff at CFSOG. For example, your therapist may talk to a colleague or supervisor in our organization in order to better understand your child's particular issues or difficulties.

For teenagers ages 13 to 17, CFSOG expects families to assent to allow the therapist to keep most discussions between the teen and their therapist confidential even from family members.

Teens should be aware that parents could file court action to open their records. CFSOG discourages this practice and reserves the right to decline services for parents who will not consent to allow the therapist to disclose only what is necessary to further their progress. CFSOG will disclose information to parents if: 1) the child is at serious risk of harming self or others; and 2) the child is involved in potentially self-destructive behavior like heavy drug use or unprotected sex; 3) there exist situations that may severely hamper treatment. In the latter case, CFSOG may choose not to share

the specifics of the information but may refuse to continue the case if the child will not self-disclose. Many times the therapist will use information shared by the child to guide and direct the parent(s) toward more effective parenting. However, CFSOG will not routinely disclose to parents issues of minor drug use, protected and safe sex practices, issues relating to sexual preference or gender expression, legal infractions, or violations of house rules that are unbeknownst to the parents. To be clear, therapy cannot be effective if children believe the therapist is an information conduit to their parents. If parents wish to discuss this matter with the therapist, they are encouraged to do so before any individual time is scheduled with the child.
Beyond that noted above, there are three exceptions to confidentiality for all clients. By law all therapists must break confidentiality: (1) if a client is threatening to hurt himself/herself or someone else in order to protect the client or the other person; (2) if child abuse is suspected; and (3) if a court of law subpoenas the records. If this happens, we will attempt to invoke privileged communication (a legal protection of your right to therapeutic confidentiality) if you or your attorney asks us to do so. However, under some circumstances, the court can override privileged communication and order us to disclose these records.

Appointments: All office visits are by appointment only and may be scheduled through the front office staff or with your therapist directly. Since consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time, as arriving negatively effects your treatment. The usual length of an appointment is 50-60 minutes. If you are unable to keep a scheduled appointment, you must notify CFSOG at least 24 hours in advance to avoid having your case closed and treatment terminated. Please leave a message if you get the agency voicemail. If you miss or cancel your appointment, you will need to contact CFSOG's office for a new appointment time.

It is very important that your child come for every scheduled appointment. When a child does not show up to their given appointment, it creates a void in the schedule where another child's treatment could have been offered. Since this is a private practice, rescheduling a missed appointment is more difficult due to limited openings in our schedule and our ongoing waiting list. Therefore, once a child has missed two (2) appointments your case will be closed, so future appointments can be offered to other clients.

Payment and Insurance Reimbursement:
The following fee schedule is applicable for all patients when services are rendered-

CPT Code	CPT Description	Amount	Initials
Therapy Services			
90791	Psychiatric diagnostic interview without medical services	$160.00	
90847	Family Psychotherapy with patient present	$120.00	
90846	Family Psychotherapy without patient present	$120.00	

90837	Individual psychotherapy, 60 minutes	$120.00	
Psychiatry Services			
90792	New Patient Diagnostic Evaluation	$300.00	
	Existing Patient Medication Therapy	$150.00	

Insured clients:
We accept all South Carolina Medicaid/HMO plans. However, it is the responsibility of the patient and/or the guarantor to cover any and all expenses not paid by the insurance plan. Anyone who is not covered by Medicaid will be provided a Super Bill, which will allow them the ability to directly seek reimbursement from their respective insurance company for Mental Health Services rendered. We cannot guarantee that you will receive payment as some providers do not recognize a Super Bill nor will they cover Mental health treatment services for out of network providers. However, we will provide this service as a courtesy.

You should be aware that your contract with your health insurance company requires that CFSOG provide the company with information relevant to the services you receive. At a minimum, we are required to provide a clinical diagnosis. Some companies require additional information such as treatment plans, summaries, or copies of your entire clinical record. We make every effort to release only the minimum information necessary for the purpose requested. This information will become a part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with your private information once it has been released to them. CFSOG is an in-network Provider with the following insurance companies: Medicaid -fee for service), First Choice/Select Health, Cenpatico/Absolute Total Care, Blue Choice/BCBS, Molina and Wellcare.

Health Insurance Portability and Accountability Act of 1996 HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available on our website at www.carolinafamily.org.

All information revealed by you in a counseling or therapy session and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form [electronic. paper, or oral]) is considered "protected health information" by HIPAA. As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization. The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in your therapist's Professional Disclosure Statement and Consent for Treatment.

Use or disclosure of the following protected health information does not require your consent or authorization:

- Uses and disclosures required by law.
- Uses and disclosures about victims of abuse, neglect, or domestic violence.
- Uses and disclosures for health and oversight activities.
- Uses and disclosures for judicial and administrative proceedings.
- Uses and disclosures for law enforcement.
- Uses and disclosures for research purposes.
- Uses and disclosure to avert a serious threat to health or safety.
- Uses and disclosure for Workers' Compensation

Your Rights as a Counseling/Therapy Client under H1PAA

- As a client, you have the right to see your counseling/therapy file.
- As a client, you have the right to receive a copy of your counseling/therapy file. This file copy will consist of only documents generated by CFSOG. You will be charged copying fees@ .25 page.
- As a client. You have the right to request amendments to your counseling/therapy file.
- As a client, you have the right to receive a history of all disclosures of protected health information. You will be charged copying fees @ $.25/page.
- As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations. If you choose to release any protected health information you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
- As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Prior to your counseling or therapy, you will receive 1) an exact duplicate of this statement and 2) your therapist's Professional Disclosure Statement and Consent for Treatment for your personal records. It will be necessary for you to sign a form indicating that you have received, read, and understand both documents. The form will be placed in your therapy file. Please do not sign the certificate if you do not understand any part of the HIPAA client's Rights or the Professional Disclosure Statement and Consent for Treatment. Your therapist will be happy to explain these documents further.

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Acknowledgements and Consents

I acknowledge that I have received and read the CFSOG Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights. I further acknowledge that I seek and consent to treatment with CFSOG. My signature below confirms that I understand and accept all the information contained in the CFSOG Professional Disclosure and Consent for Treatment and the HIPAA's Client's Rights.

_____ _____

Signature of Client/Parent Guardian under 18) Date

If more than one individual (e.g. spouse or family member) is seeking therapy, each must sign below to participate in treatment.

I confirm that I have received and read the CFSOG Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights. I further acknowledge that I seek and consent to treatment with CFSOG. My signature below confirms that I understand and accept all the information contained in the CFSOG Professional Disclosure and Consent for Treatment and the HIPAA's Client's Rights.

_____ _____

Person's Signature and Relationship to Client Date

_____ _____

Person's Signature and Relationship to Client Date

_____ _____

Person's Signature and Relationship to Client Date

_____ _____

Person's Signature and Relationship to Client