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**New Client Information**

*Welcome! I’m glad you’re here. I’d like to take this opportunity to answer some of your questions and clarify my procedures.* ***Please read and sign all parts of these forms, initialing the bottom of each page.*** *Many of the items present are required by law in order to inform you of your rights, opportunities, and obligations. If for some reason you cannot sign all parts of these forms, please discuss your reason with me during your first session. We can discuss any further questions at that time as well. Thank you.*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Full Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How may I contact you? (Please initial all that apply) \_\_\_\_\_\_Home Address \_\_\_\_\_Email \_\_\_\_\_Cell Phone \_\_\_\_\_Home Phone

If I am allowed to contact you by phone, may I leave a message with a person or voicemail identifying who I am? \_\_\_\_Yes \_\_\_\_\_No

May I send you appointment reminders via text and email? \_\_\_\_Yes \_\_\_\_\_No

Employment Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, please contact:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial \_\_\_\_\_\_\_**

**POLICIES AND PROCEDURES**

# Appointments and Hours

Appointments are scheduled on weekdays, evenings, and Saturdays, depending on my schedule. You may call or email Monday through Friday, 9:00 a.m. until 5:00 p.m. to schedule, change, or cancel appointments. If you need to cancel an appointment after office hours, please leave a message on my voice mail. Please note the date and time of your call, as **24-hour notice of cancellation is required to avoid being charged for the canceled session**.

# Charges

**Client payment via cash or check, credit card, or health savings card is expected at the time of service**. Cash or check is preferred. I do not bill for services. Please make checks payable to “Kristin Nakhla, Therapist, PLLC.” If you anticipate a problem in paying your bill, please talk with me regarding your situation. *There will be a $20 charge for checks drawn on insufficient funds.*

# Fees

I am not contracted with any major insurance companies. Many insurance plans have Health Saving Accounts or Flexible Spending Accounts. Verify with your insurance company that yours can be used for therapy services. I am happy to provide a superbill for you to submit to your insurance company if needed.

Services are by appointment only. Appointments are generally 50 minutes long. Family sessions are generally 80 minutes long. Fees include my time on your behalf for record keeping, preparation, etc.

I offer a sliding fee *based on gross household income* for those that cannot pay the full fee of $100 per 50 minute session. Family and marriage counseling may require an 80 minute session. The sliding scale operates as follows: If your gross household income is less than $70,000 you pay $80 ($120 for an 80 minute session), if $70, 000-$79,999 you pay $90 ($135 for an 80 minute session), if $90,000 or above you pay $100 ($150 for an 80 minute session).

Letters, formal reports, travel time for out-of-office-services, etc. will be charged $200 per hour.

*Telephone calls longer than 5 minutes will be pro-rated & charged at the regular counseling rate.*

# Cancellations

**If you need to cancel or change an appointment, be sure to give me** **at least a 24-hour notice by emailing, calling, or texting 919-753-5717 Monday-Friday 9:00 a.m.-5:00 p.m. Failure to give a 24-hour cancellation notice will result in you being charged the full session fee for the appointment time reserved for you. Not providing a 24-hour cancellation notice means that another person is unable to use that appointment time.**

# Non-Emergency Phone Calls

It is not always possible for me to immediately return non-emergency phone calls (i.e., a life is not in danger), especially since I am not in the office on a full-time basis. You may either leave a message, and I will attempt to check my voice mail at least once every 24 hours and do my best to return calls within 48 hours. Please understand, however, that this is not a guarantee. I ask that since I am making an attempt to respect your needs, you would likewise make an effort to respect my personal time. Under no circumstances may I be contacted at home.

# Crisis Situations

By nature, this is **NOT** a crisis intervention facility. If a life threatening or other crisis situation arises, please take the following steps:

* Call your local police; 911 (ask for a Crisis Intervention Team officer)
* National Suicide Prevention Lifeline at **1-800-273-TALK (8255)**
* Alliance Behavioral Healthcare (Phone counseling) **800-510-9132**
* Therapeutic Alternatives (Mobile Crisis Team will come to your home) 877-626-1772
* UNC Health Care at Wakebrook (24-hour crisis center) 107 Sunnybrook Rd, Raleigh NC 27610; 919-250-1260 then,
* Contact me or leave a message regarding the situation.

**IF YOU FEAR THAT YOU MAY BE IN DANGER OF HURTING YOURSELF OR ANYONE ELSE, YOU SHOULD GO TO A LOCAL EMERGENCY ROOM FOR TREATMENT, OR CALL 911.**

**Initial \_\_\_\_\_\_**

# CLIENT RIGHTS

# Questions

At any time, clients may question and/or refuse therapeutic or diagnostic procedures or methods, or gain whatever information they wish to know about the process and course of counseling. *This is your right as a client*. If you are in need of further professional services that are beyond the scope of my competence, I will assist in referring you to such a specialist. If during the course of counseling you have any questions about your treatment, please don’t hesitate to ask. I continually strive to provide the highest quality of professional service available, and am genuinely interested in your honest feedback regarding my work with you.

# Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have created a notice which describes how health information about you (as a client of this office) may be used and disclosed, and how you can get access to your Protected Health Information (PHI). In the course of counseling, I will create records regarding you and the treatment I provide you. I am required by law to maintain the confidentiality of this health information that identifies you. I am also required by law to provide you with a notice of my legal duties and the privacy practices that I maintain concerning your PHI. By federal and state law, I must follow the terms of the Notice of Privacy Practices that are in effect at the time. The Notice of Privacy Practices (NPP) is contained in the last pages of this packet. **Please read it and keep it with you.**

# Confidentiality and Statement of Supervision

Confidentiality is separate from privacy and is one of your most important rights as a client. You are assured of confidentiality, which is protected by both ethical practice and by North Carolina and Federal law. There are, however, important exceptions to confidentiality, some of which are legally mandated. Additionally, supervision and/or consultation may be necessary under certain circumstances for the purpose of providing the best possible care and treatment. These exceptions are as follows:

1. If I become aware, or suspect, that a child or adult may be experiencing abuse or neglect, I am required by law to report this to the appropriate authorities.
2. If you present a believable threat to harm yourself, I am required by law to take action to prevent such harm, such as the possibility of having you hospitalized.
3. If you present a believable threat to do harm to another person, I am required by law to take reasonable action to prevent you from carrying out such a threat. This may include telling the identified potential victim and/or local law enforcement agencies.
4. For your quality of care and for the purposes of clinical supervision, therapy sessions may be discussed with professional supervising staff, as deemed necessary. As a Licensed Clinical Social Work Associate, the State of North Carolina requires me to maintain clinical supervision until I reach 3, 000 hours of clinical experience.

I will always maintain the utmost professional manner of handling such situations. Consent for treatment by me implies consent for information to be shared for the purposes of supervision/consultation as outlined above and in my NPP.

# *I have read the above information, received the opportunity to have questions answered to my satisfaction, and give my consent to treatment with Kristin Nakhla, Therapist.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client signature) \_\_\_\_\_\_\_\_\_\_\_\_(Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent signature if client is a minor) \_\_\_\_\_\_\_\_\_\_\_\_(Date)

**Initial \_\_\_\_\_\_**

**Payment Agreement**

If your gross household income is less than $70,000 you pay $80 ($120 for an 80 minute session), if $70, 000-$79,999 you pay $90 ($135 for an 80 minute session), if $90,000 or above you pay $100 ($150 for an 80 minute session).

▫I agree to pay $100 per 50 minute session ($150 for an 80 minute session) because my household income is $90,000 or above. I will pay at the time of service. If at any time I am unable to keep this agreement, I will promptly advise my therapist.

▫I agree to pay $ \_\_\_\_\_\_\_\_\_ for each 50 minute session, or $\_\_\_\_\_\_\_ for each 80 minute session. This is a reduction from the normal $100 per 50-minute fee. I will pay at the time of service. If at any time I am unable to keep this agreement, I will promptly advise my therapist. I understand that this fee is based on gross family income to date, and will notify my therapist if my financial situation changes. If it does, this fee will be renegotiated at that time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Client’s name or responsible party: PLEASE PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Client signature or responsible party) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date)

**Legal Cases**

Should you subpoena me, with or without approval, or involve me in court related processes, you agree to pay a retainer fee of $1,200 that is due at the time a subpoena is served. The charge for court-related services of any kind is $200 per hour, including status reports, case preparation, witness time, and any wait time related to a court related process. Fees incurred for these services will not be filed with your insurance company. Please keep in mind that a court ordered subpoena terminates protection of client-therapist privilege and the duty to maintain confidentiality.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Client’s name or responsible party: PLEASE PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Client signature or responsible party) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date)

**Consent to use and disclose your health information**

*This form is an agreement between you, the client, and Kristin Nakhla, Therapist, PLLC and is required by law under HIPAA regulations. (When the word “you” is used below, it will mean your child, relative, or other person if you have written their name here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If not, it refers to you.)*

When I examine, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need this information to decide what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or who need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and, *with authorization*, send it to others. The Notice of Privacy Practices (NPP), enclosed in this packet, explains in more detail your rights and how we can use and share your information. **Please read this notice BEFORE you sign this consent form**. **If you do not sign this consent form agreeing to what is in our NPP, legally I cannot treat you.**

In the future, I may change how I use and share your information and so may change our Notice of Privacy Practices. If any changes are made while you are an active client, you will receive a copy from me at that time. You may also request a current copy from me at any time.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment, or administrative purposes. I will need to have this request in writing. Although I will try to respect your wishes, I am not required by law to agree with these limitations. However, if I do agree and the request is feasible, I promise to comply with your wish.

After you have signed this consent form, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time forward, but I may already have used or shared some of your information and cannot change that.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client signature) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent signature if client is a minor) (Date)

Date NPP Received by client/parent of client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Initial \_\_\_\_\_\_**

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| --- | --- |
| Description: Description: j0237808 |  **Holly Springs Counseling Center PLLC** |

 **Contract Provider Disclaimer**

**Holly Springs Counseling Center PLLC is composed of Independent Providers who render care and treatment to their clients at Holly Springs Counseling Center PLLC.**

**Your therapy/service will be managed by the Independent Providers who are not employees of Holly Springs Counseling Center PLLC but rent space and provide services for clients at Holly Springs Counseling Center PLLC.**

**Each Independent Provider is solely responsible to maintain individual liability insurance. Please note that the foregoing disclaimer applies not only to therapies performed by Independent Providers, but also to any other claims, damages, or liabilities you may have out of your dealings with your Independent Provider.**

**The Providers at Holly Springs Counseling Center PLLC are solely responsible for judgments and related treatments. Holly Springs Counseling Center PLLC is not liable for any act or omission, including negligence, committed by any Independent Provider, or program run by any Independent Provider at Holly Springs Counseling Center PLLC. Holly Springs Counseling Center PLLC shall not be held liable for services performed by these Independent Providers.**

**Upon signing this form, I acknowledge that I have read and understood the foregoing and accept its terms.**

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|  |  |  |  |       |
| **Signature: Client/Responsible Party**  |  |  |  | **Date** |
|  |  |  |  |  |
| **Signature: Client/Responsible Party**  |  |  |  | **Date** |