ASPEN
mental health

Patient Profile

Date_____ How Did You Hear About Us? _____

First Name _____Middle Initial_____Last Name_____

Address (No PO Boxes)_____

City_____State_____Zip_____

County_____ Date of Birth_____ Age_____

Marital Status_____

Home Phone_____ Work/Cell Phone_____

Email_____

Legal Guardian/Relationship_____

Employer or School Attending/Grade_____

Emergency Contact Name_____ Phone_____

Primary Physician_____ Phone_____

Current Medications_____

Allergies_____

Any Known Communicable/Infectious Diseases _____

Concerns Requiring Counseling_____

Do You Need Language Translation Services? _____yes _____no

Do You Have Medicare? _____yes _____no

Insurance Information

Insurance Company_____Name of Insured_____

Insured's SSN #_____Insured's D.O.B_____

Insured's Policy #_____Insured's Group #:_____

Insured's Employer_____

Insured's Relationship to Client _____Authorization #:_____

Informed Consent

Time Commitment: Today's appointment will take approximately 1 to 1.5 hours. We realize that beginning counseling is a major decision and you may have many questions. This document, along with the "Clients Rights and HIPPA Information" form, strives to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask.

Risks and Benefits: As with any medical or therapy service, there are inherent risks and benefits. These will be discussed with you today as it relates to your specific circumstance. By signing this document, you are consenting for treatment. You have the right to refuse treatment or withdraw your consent for treatment at any time. You may also withdraw your consent for a particular treatment modality at any time. If you withdraw your consent for a particular treatment modality, your counselor will determine if another viable treatment modality is available. If all appropriate treatment modalities are refused, your counselor will work with you to determine appropriate next steps (i.e., ending services, transfer to a new counselor, transfer to a different agency). Your counselor's recommendations will not limit your right to refuse treatment at any time. If you have questions, please ask your counselor.

Confidentiality: Your verbal communication and clinical records are strictly confidential except for: **a)** Information *(diagnosis and dates of service)* shared with your insurance company to process your claims. **b)** Information you and/or your child or children report about physical or sexual abuse. **c)** Any infectious diseases that a client will intentionally spread to harm others. *(Please Note: North Carolina State Law requires your counselor to report abuse to the Department of Social Services, as well as, report any intent to harm others to local authorities.)* **d)** When a release of information has been signed by the client or client's legal guardian to have specific information shared. **e)** If a client or client's legal guardian provides information that informs the counselor that you are in danger of harming yourself or others. **f)** Information necessary for case supervision or consultation. **g)** When required by law.

Culturally Responsive Care: It is our mission to provide health equity and eliminate health care disparities to all individuals through the services we provide. It is our goal to provide care that is sensitive to culture, religion, disability, language and other held individual/family beliefs or qualities. Aspen Mental Health Therapy and Consulting, PLLC does not discriminate against any people groups based on their race, color, religion, national origin, ancestry, sex, sexual orientation, gender identity, gender expression, age, genetic information, or disability. When it is not possible to service individuals or families due to unavailability of an employee/contractor that speaks the patients' language, interpreter services are not available, or employee/contractor does not have the clinical expertise for adequate treatment, we will make every effort to refer patients to qualified clinicians that can perform services outside of our agency. Please discuss any questions you have regarding culturally responsive care at your intake appointment. You may visit www.aspenmentalhealth.com for a copy of our culturally responsive care policy or request a copy from your therapist.

No Surprise Act:
Under Section 2799B-6 of the Public Health Service Act, if you are uninsured, not seeking to file a claim with your healthcare insurance, or you are seeking services from a provider out of network with your insurance health plan, you are entitled to receive a verbal and/or written "Good Faith Estimate" of expected charges. If the above applies, you should have received an estimate of per session costs at the time that your appointment was scheduled, when you requested information about our services, or before your appointment with a therapist begins. A Good Faith Estimate is not a guarantee that treatment will be completed within a certain number of sessions, as it is impossible to know the amount of sessions an individual may require. Any estimated time frames you receive are your therapist's best guess based on their experience with similar circumstances and/or diagnosis. Under the No Surprise Act, if you receive a bill that is at least $400.00 more than your Good Faith Estimate, you can dispute that bill. At Aspen, we bill per session, and payment is collected at the time services are rendered. We also believe it is your right and privilege to be in control of your mental health wellness journey. As such, you have the right to disagree with treatment recommendations or discontinue services at any time during the course of treatment. For questions or more information about your right to a Good Faith Estimate, visit www.cms/nosurprises.

Appointments and Professional Fees: Appointments are generally 45 to 60 minutes in length. Initial intakes are billed at $190.00 and counseling sessions are billed at $165.00. Cost of services may be less, depending upon our agreement with your insurance provider. Other services including report writing, telephone conversations longer than 10 minutes, attendance and meetings with other professionals, court appearances/involvement, etc. are billed at an hourly rates of $110.00 per hour and may not be covered by your insurance. A $110.00 up-front fee is charged for any mandatory court appearances. **We do not offer court testimony or court letter writing services. We also do not specialize in or become involved in custody or family related disputes. Our therapists are not available to offer professional opinions on such matters.**

Please be aware that in most cases we are unable to complete FMLA and disability paperwork. At your request, and upon signature of a release of information, we can provide requested records and/or provide a summary of treatment to third parties that you specify. We are also happy to work with your physician to collaborate treatment. However, most disability and FMLA proceedings require medical recommendations that will require the opinion and expertise of a licensed physician. Please discuss with your counselor any specific needs that you have regarding this. Record summaries are billed at $45.00.

As a courtesy, we will bill your insurance company, HMO, responsible party, or third party payer for you. Co-pays must be paid in full at each session. If your insurance deductible has not been met, the full session fee is due at the time of service. **If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time.** If your account has not been paid for 60 days, or arrangements for payment have not been agreed upon, legal means may be used to secure payment. This could involve, but is not limited to, hiring a collection agency or utilizing a small claims court. You agree to be responsible for all cost of litigation, including attorney's fees. In most collection situations the only information released is the client's name and address, nature of services provided, and the amount due. We sincerely appreciate your cooperation. At any

time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You should also be aware that most insurances companies require you to authorize us to provide them with confidential information such as clinical diagnoses, treatment plans/summaries, or copies of records. This information becomes part of the insurance company's files.

Initial Appointments/Intakes Are No Guarantee of Future Services: The initial appointment allows the therapist to determine client needs and determine if our practice/therapist can meet those needs. If the therapist determines that he/she cannot meet the client's needs, the client will be notified after the therapist makes this determination. You agree that you are responsible for seeking out a new therapist for yourself or your child. Please note, that Aspen Mental Health reserves the right to discontinue services at any time a therapist determines that he/she can no longer meet a client's needs.

Appointment Policy (No Shows/Cancellations/Tardiness): In efforts to meet the needs of our community, we are unable to tolerate no shows. (A no show is defined as failure to attend a scheduled appointment, failure to cancel without 24 hours notice, or having to reschedule due to tardiness). By signing below, you acknowledge that you understand the following policy: Any therapist at Aspen Mental Health may terminate services after one no show. In the event, that the therapist continues services after a no show, Aspen Mental Health will terminate services after 2 no shows. If you must reschedule or cancel an appointment, please phone 24 hours in advance in order not to be charged for the session. A pattern of missed appointments will lead to additional charges that are not covered by insurance and may result in an end to treatment. Sessions are scheduled by appointment only. If you arrive more than 15 minutes late for your appointment, your therapist may no longer be available. Non-Medicaid clients will be charged $50 for sessions missed or cancelled with less than 24 hours notice. These fees are not covered by insurance.

Treatment of Minors: By consenting for the treatment of your minor child/adolescent, you are certifying that you have legal custody of the child and are legally able to make decisions for the minor. You also understand that we require all legal guardians/custodians to consent for the treatment of minors, and that all legal guardians/custodians have a right to review our records regarding the minor. If you are in a current custody dispute, or anticipate a custody dispute arising, we recommend that you consult your attorney before consenting for your child/adolescent to engage in treatment.

Client Contact: By signing below, you acknowledge and consent that Aspen Mental Health Therapy and Consulting, PLLC may contact you regarding your care at the numbers, address and/or email you provided on your patient profile.

Emergencies: In an emergency situation, for which the client/guardian feels immediate attention is necessary, please contact your counselor via their cell phone number or the Aspen staff member on call at 336-907-2050. If no contact can be made, the client/guardian understands that they should contact Daymark 24 Hour Mobile Crisis Hotline at 877-492-2785, Suicide Prevention Lifeline 1-800-273-8255, Emergency 911, or as a last resort, visit a local emergency room. This agency will follow those emergency services with standard counseling and support as necessary. In the event of an in office medical or mental health emergency you agree that we may contact emergency services and/or administer measures that may include CPR, Narcan, AED Defibrillator, or other necessary measures.

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Crisis Response: By signing below, you acknowledge and consent that Aspen Mental Health Therapy and Consulting, PLLC may seek immediate medical/crisis attention for you or the minor child/adolescent whom you provide permission for us to treat. In the event that an emergency or crisis arises during a treatment session, or if you contact us to notify us of an emergency or crisis, you give us permission to contact Daymark Mobile Crisis, 911, or other emergency services providers to assist you with your emergency or crisis event. Further, you give us permission to release your contact information and any information that emergency services may need in assisting you while in crisis. You understand that the emergency service provider that responds to your crisis/emergency will be responsible for your care until you are released from their care. You agree to follow up with our office upon your release from crisis care or hospitalization so that we may continue counseling and/or determine next steps for your care.

Social Media Policy: Your counselor must conduct him/herself in a professional manner regarding the use of social media and Internet. The following outlines what you can expect from your counselor. This policy will be updated as technology changes. We will notify you in writing of any changes made.

- **Friending:** We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.
- **Interacting:** Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact us. These sites are not secure and engaging with us this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact us between sessions, the best way to do so is by phone at 336-827-0089.
- **Use of Search Engines:** It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with us via our usual means, coming to appointments, phone, or email, there might be an instance in which the use of a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations, and if we ever resort to such means, we will fully document it and discuss it with you when we next meet.
- **Business Review Sites:** You may find our counseling practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. If you should find our listing on any of these sites, please know that the listing is NOT a request for a testimonial, rating, or endorsement from you as a client. You have a right to express yourself on any site you wish. Due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative.

- **Email:** By signing our informed consent, you acknowledge and are giving us permission to email you regarding any need in your counseling as an active or inactive/closed client. You are acknowledging that email is not completely secure or confidential. If you choose to communicate with us by email, be aware that all emails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails we receive from you and any responses that we send to you become a part of your medical record.

Thank you for taking the time to review our Social Media Policy. If you have questions or concerns about any of these policies and procedures, bring them to your therapist's attention so that discussion can be had about such concerns.

Complaints/Grievances: Clients are encouraged to discuss complaints, grievances, and concerns with their counselor and/or Aspen Mental Health. If concerns are not resolved, or if you believe you have experienced harmful or unethical treatment by your counselor, and you do not feel comfortable discussing it with your counselor or our agency, you may wish to contact your insurance provider or the counselor's respective licensure board. Your counselor's professional disclosure statement will reflect the name and contact information of their licensure board.

By signing below, you acknowledge receipt and agreement to “Informed Consent,” which includes your consent for treatment. You also acknowledge receipt and agreement to “Client Rights and HIPAA Information.” We are happy to provide you a copy of “Client Rights and HIPAA Information” at your request, or you may review these at www.aspenmentalhealth.com under the “New Client” tab.

Agreement to Informed Consent and Acknowledgement of Receipt of Client Rights & HIPAA Information:

_____

Signature of Client or Guardian **Date**

_____

Signature of Clinician **Date**

Consent For Treatment of Children or Adolescents:

I/We consent that _____ *(minor’s name)* may be treated as a client at Aspen Mental Health. Please be aware that the law may provide parents/guardians the right to examine treatment records. It is our policy to provide parents/guardians access to information about treatment. However we also ask parents/guardians to allow us to keep a minor’s confidences on specific information. We will provide you with general information about the minor’s treatment sessions. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children.

_____

Signature of Guardian/Custodian(s) **Date**

To be Completed with Your Counselor in Session:

I have reviewed and been given a copy of my counselor’s Professional Disclosure Statement. I understand the information provided to me.

_____

Signature of Client or Guardian **Date**

_____

Signature of Clinician **Date**

Important Policies and Additional Consents

Initial Appointment Policy

Initial appointments or intakes are not a guarantee of continued service. This appointment allows the therapist to determine client needs and to determine if our practice and the therapist can meet those needs. If the therapist determines that he/she cannot meet the client's needs, the client will be notified after the therapist makes this determination. You agree that you are responsible for seeking out a new therapist for yourself or your child. Please note, that Aspen Mental Health reserves the right to discontinue services at any time a therapist determines that he/she can no longer meet a client's needs.

_____

Signature of Client or Guardian **Date**

Appointment Policy (No Shows/Cancellations/Tardiness) and Termination of Services

In efforts to meet the needs of our community, our office is unable tolerate no shows. **(A no show is defined as failure to attend a scheduled appointment, failure to cancel without 24 hours notice, or having to reschedule due to tardiness).** By signing below, you acknowledge that you understand and agree to the following policy: Any therapist at Aspen Mental Health may terminate services after one no show. In the event, that the therapist continues services after a no show, **Aspen Mental Health will terminate services after 2 no shows**. If you must reschedule or cancel an appointment, please phone 24 hours in advance in order not to be charged for the session. If you arrive more than 15 minutes late for your appointment, your therapist may no longer be available. Non-Medicaid clients will be charged $50 for sessions missed or cancelled with less than 24 hours notice. These fees are not covered by insurance.

By signing below you also acknowledge your responsibility to schedule appointments as needed with your/your child's therapist. You also understand and agree that after a period of no appointments scheduled within 90 days that Aspen will assume that you/your child are not returning for services and will automatically discharge you or your child from our care. Any further services requested will require new patient information to be completed.

_____

Signature of Client or Guardian **Date**

Consent to Text Usage for Appointment Reminders:

By signing below, you are agreeing that our office may contact you via text message to remind you or your child of a scheduled appointment. You acknowledge that you are responsible for the security of your text messages. Text messages may include the date and time of the appointment, our office name and telephone number, and the name of the therapist. If you do not wish to be contacted via text, please do not sign below.

_____

Signature of Client or Guardian **Date**

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Authorization For Release of Information

I (We) authorize Aspen Mental Health to release, disclose, receive or exchange information from the clinical record of:

_____

Name of client/recipient of mental health services Date of birth

To or from the following persons/entities and allow such information to be inspected and copied by:

_____

PCP/Person/Entity PCP/Person/Entity Address

Nature of information to be disclosed: _____

State specific nature of information to be disclosed

For the purposes of _____

State specific purpose of information to be disclosed

By initialing "yes" to the following, I agree that information to be released and/or exchanged includes any available ***substance use/abuse or HIV/Infectious disease*** information. Please initial "no" if you do not wish for this information to be disclosed. **CLIENT INITIALS**: yes_____ no_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to the office of Aspen Mental Health. I understand that a revocation is not valid to the extent that Aspen Mental Health has acted in reliance on such authorization. This authorization is valid until _____ *(Date)*.

A copy of this release shall have the same force and effect as the original. By signing below I acknowledge that I have been notified that release/disclosure of information may only occur with a consent unless it is an emergency or for other exceptions as detailed in the General Statutes or in 45 CFR 164.512 of HIPAA.

_____

Client Signature 12 yrs. or Older **Date**

_____

Parent/Guardian Signature **Date**

_____

Witnessed by Counselor **Date**

NOTICE TO RECEIVING FACILITY/COUNSELOR: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

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UCLA PTSD REACTION INDEX FOR CHLDREN/ADOLESCENTS - DSM-5©

Child/Adolescent Name: _____ Sex: □ Girl □ Boy
Date (*month, day, year*) ____/____/____

TRAUMA/LOSS HISTORY SCREENING QUESTIONS:
Place a check mark in the box on the left for each type of trauma /loss experience that has occurred. ***Sometimes people have scary or violent things that happen to them where someone could have been or was badly hurt or killed.***

□ **Serious Accidental Injury**: Have you ever been in a bad accident (like a serious car, bus, train or bicycle accident or a bad fall) where you or someone else was or could have been badly hurt or killed? Have you ever seen a bad accident where someone was badly hurt or killed?

□ **Illness/Medical Trauma**: Have you ever been so sick that you and your parents (or people taking care of you) were scared that you might die? Did you have a medical treatment that was very scary or painful? Did you ever see someone you really care about get so sick that you were scared they might die?

□ **Community Violence**: Did you ever see a bad fight or shooting in your neighborhood, like between gangs? Were you afraid of getting badly hurt or killed? Have you seen someone mugged, robbed, stabbed or killed in your neighborhood?

□ **Domestic Violence**: Have you ever seen adults you live with get in a bad fight with each other, where someone got punched, kicked or hit with something? Have adults you live with threatened to hurt each other? Have you ever seen an adult you live with forced to do something sexual by another adult you live with?

□ **School Violence/Emergency**: Were you ever at school when something really scary happened, like a shooting, a stabbing, a fire, where you or someone else got badly beaten up or someone attempted or committed suicide?

□ **Physical Assault**: Have you ever been badly physically hurt (punched, kicked, stabbed) by someone outside of your family or who was not taking care of you? Have you ever been badly hurt by someone outside your family, like someone in your neighborhood, a boy or girl friend or a stranger?

□ **Disaster**: Have you ever been in a natural disaster, like a hurricane, tornado, earthquake, flood or wildfire where you were hurt or could have been hurt or killed? Have you been in a natural disaster where you saw someone badly hurt or killed? Have you been in a place where there was a chemical spill or explosion?

□ **Sexual Abuse**: Did someone who was taking care of you ever force you to do something sexual? Did someone taking care of you ever make you watch something sexual?

□ **Physical Abuse**: Have you ever been badly hurt (punched, kicked, stabbed, shaken) by someone who is in your family (like a parent, brother or sister) or someone who was taking care of you? Have you seen another child in your family being badly physically hurt by a parent, caregiver or legal guardian?

□ **Neglect**: Has there ever been a time when someone who should have been taking care of you didn't, like they didn't take you to a doctor when you were really sick, they left you alone for too long, didn't make sure you were going to school or didn't do their best to keep you healthy or safe?

□ **Psychological Maltreatment/Emotional Abuse**: Did anyone in your family ever keep telling you that you are no good, keep yelling at you or keep threatening to or send you away?

Name: _____
DOB: _____
Record/Alpha Number: _____
Medicaid/Ins. Number: _____

Treatment Plan Signature Page

I have participated in the assessment and development of the crisis plan, as necessary, and the treatment plan. I agree with the goals and services/supports to be provided.

I am willing to participate in the recommended frequency of sessions.

I understand the treatment plan will be reviewed/updated and I will give input on progress and/or concerns.

This signature page serves as the order for services verifying that services have been deemed medically necessary by the rendering provider.

Date	Client/Guardian/Clinician Signature	Title