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Client Profile:

Date_____ How Did You Hear About Us?_____

Client Legal Name _____ Preferred Name_____

Address (No PO Boxes)_____

Preferred Contact Number _____Email_____
Okay to leave a voicemail at the contact number? ☐ Y ☐ N
Okay to email? ☐ Y ☐ N

Date of Birth_____ Age_____ Marital Status:_____

Primary Physician Office:_____Phone_____

Current Medications_____

Race/Nationality/Ethnicity:_____ Translation Services Needed? ☐ Y ☐ N

Spiritual/Religious Preferences (if applicable): _____

Legal Guardian Information (if applicable):

Parent/Guardian 1 Name	Relationship to Client	Contact Number	Email

Okay to leave a leave a voicemail at the contact number? ☐ Y ☐ N
Okay to email? ☐ Y ☐ N

Parent/Guardian 2 Name	Relationship to Client	Contact Number	Email

Okay to leave a leave a voicemail at the contact number? ☐ Y ☐ N
Okay to email? ☐ Y ☐ N

Emergency Contact Information:

Contact Name	Relationship to Client	Contact Number

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Concerns for Counseling:
Please describe the concern(s) that brings you to counseling and any goals that you hope to accomplish during counseling:

_____

_____

_____

_____

Current Symptoms/Behaviors (select all that apply)

☐ Mood Swings	☐ Feeling Hopeless	☐ Obsessions/Compulsions
☐ Extreme Sadness	☐ Trouble Concentrating	☐ Changes in Sleep Habits
☐ Appetite Changes	☐ Weight Changes	☐ Lack of Enjoyment of Activities
☐ Memory Problems	☐ Feeling Stressed	☐ Feelings of Extreme Happiness
☐ Hyperactivity	☐ Restlessness	☐ Self Esteem Problems
☐ Easily Irritable	☐ Racing Thoughts	☐ Problems Getting Along with Family
☐ Feeling Guilty	☐ Feeling Tearful	☐ Problems getting along with Peers
☐ Feeling Fearful	☐ Problems with Anger	☐ Trouble Performing at Work/School
☐ Feeling Anxious	☐ Lack of Energy	☐ Complaints of Physical Pain
☐ Avoiding Others	☐ Muscle Tension	☐ Sudden Feelings of Panic
☐ Panic Attacks	☐ Acting Aggressively	☐ Thoughts of hurting self/others

Please mark the areas of life functioning that are currently impacted by the symptoms/behaviors selected above.

☐ Romantic Relationships	☐ Temper Control
☐ Job/School	☐ Family Relationships
☐ Anxiety Level	☐ Friendships
☐ Sleeping Habits	☐ Physical Health
☐ Finances	☐ Mood
☐ Sexual Function	☐ Concentration:
☐ Eating Habits	☐ Alcohol/Substance Use

Please describe any major changes that have happened over the past year:

_____

_____

_____

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Mental Health History:
Please list any prior mental health diagnosis received:

_____

_____

Please describe any hospitalizations for mental health concerns in the past:

_____

_____

Please describe any traumatic events witnessed or experienced:

_____

_____

_____

Suicidal/Self-Harm/Homicidal Ideation History:
Any serious thoughts of harming self? ☐ Y ☐ N
Any past suicide attempts? ☐ Y ☐ N
Any serious thoughts of harming others? ☐ Y ☐ N
Any past attempts to injure or harm others ☐ Y ☐ N
Any non-suicidal self-harming behaviors (cutting, burning, scratching)? ☐ Y ☐ N

If you answered yes to any question in this section, please describe:

_____

_____

_____

_____

Additional Information:

Is there anything else that you the therapist to know?

_____

_____

_____

_____

_____

Informed Consent

Please review, sign and date in the indicated blanks. Please let an office staff or your therapist know if you have any questions.

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 HIPAA 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. You may visit www.aspenmentalhealth.com for a copy of our culturally responsive care policy or request a copy from your therapist.

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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.

Clinician Supervision: Your clinician may be provisionally licensed, as is usually indicated by their licensing title ending in the letter A. (e.g. LCMCHA, LCSWA). Provisionally licensed clinicians are required to attend weekly confidential supervision to assist them in refining clinical skills by collaborating with a specially trained, board approved, supervising clinician. By proving your informed consent you agree that the clinician may discuss your presenting concerns and therapy needs with their supervisor on an ongoing basis. Audio and/or video recordings of client sessions also greatly aid in this process. Your clinician may discuss and obtain your consent for audio/video recordings for supervision purposes. Confidentiality of any recordings are handled in a similar manner as clinical records; adhering to the same standards of HIPPA and the ACA Code of Ethics.

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. The cost of services may be less, depending upon our agreement with your insurance provider or in the instance of a sliding scale agreement. Other services including report writing, telephone conversations longer than 10 minutes, attendance and meetings with other professionals, etc. are billed at an hourly rate of $110.00 per hour and may not be covered by your insurance.

Court Appearances/Child Custody: Please be aware that our therapists do not provide court appearance services, or write letters for court. Our therapists are also unable to evaluate or make recommendations regarding child custody or make visitation recommendations. In the event, that an Aspen therapist is compelled to appear in court on your behalf due to subpoena/court order/or otherwise, you agree to an hourly rate of 200.00 per hour and agreed to compensate for any loss in wages, legal counsel expense that the therapist may incur, or other expenses incurred due to such appearances. A $200.00 up-front fee is charged for any mandatory court appearance.

FMLA: 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.

Insurance, Co-pays, and Deductibles: 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 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. On occasion, the therapist may need to staff this with their supervisor before they can make 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 also reserves the right to discontinue services if it is determined during treatment that the therapist is unable to meet a client's needs. In this case, we will work with the client to transition care as appropriate.

Client Scheduling and Discharge:
You may schedule future appointments by calling the office @ 336-827-0089 or by scheduling in sessions with your therapist. By signing the informed consent, you 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 60 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 be treated as a new patient appointment.

Appointment Policy (No Shows/Cancellations/Tardiness): In efforts to meet the needs of our community and to ensure consistency in care, Aspen is unable to allow frequent no shows or cancellations. (**A cancelation is defined as canceling an appointment at least 24 hrs in advance. A no show is defined as failure to attend or cancel an appointment giving 24 hours advance notice, or having to reschedule an appointment due to tardiness).** By signing below, you are

agreeing to the following policy: **Aspen will discontinue services after 2 no shows or 5 missed sessions(no shows/cancellations) occur within a 6 month period.** If we notice a pattern of missed appointments, we will explore with you if treatment continues to be appropriate. Any services terminated due to no shows or frequent cancellations will require a 12 month waiting period before services can be obtained with Aspen again. If you must reschedule or cancel an appointment, please phone 24 hours in advance. **Clients will be charged $100 for sessions missed or cancelled with less than 24 hours' notice.** These fees are not covered by insurance. Sessions are scheduled by appointment only. Please be aware that if you arrive more than 15 minutes late for your appointment, your therapist may no longer be available.

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 Daymark's 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.

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 and have been put into practice for your protection and to reduce the possibility of dual relationships.

- **Friending:** We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.).
- **Interacting:** Please do not use Social Networking sites to contact us. These sites are not secure and engaging with us this way could compromise your confidentiality. The best way to reach us 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, Google or Healthgrades. Some of these sites include forums in which users rate their providers and add reviews. These listings are NOT a request from our practice for a testimonial, rating, or endorsement from you as a client. Due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative.
- **Email:** If you choose to communicate with us by email you are acknowledging that email is not completely secure or confidential. The use of telephone and our secure HIPPA complaint communication portal MIYO are preferred methods of communication. By signing our informed consent, you acknowledge and give us permission to communicate with you via email. Any emails we receive from you and any responses that we send to you may become a part of your medical record.

Technology Assisted Documentation:
Your clinician may utilize a technology assisted documentation program called Blueprint as part of their effort to provide excellent care. Blueprint temporarily record sessions or uses counselor dictated information to automatically generate progress notes (a required form of clinical documentation). After a progress note is generated, recordings are automatically deleted from Blueprint's servers and database. Use of this technology allows your therapist to be fully present during your sessions and provide focused care.

Blueprint's software is HIPAA compliant and SOC 2 Type 2 certified. Blueprints systems, policies, and processes are audited on an ongoing annual basis to ensure Blueprint meets certain data privacy and security standards. By signing this informed consent, you are agreeing to allow your clinician to record your sessions and utilize software to assist them in generating progress notes to document these encounters.

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.

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

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," provided to you at www.aspenmentalhealth.com under the "New Client" tab. A printed copy can also be made available to you at your request.

_____

Signature of Client or Guardian **Date**

_____

Signature of Clinician **Date**

Agreement to Professional Disclosure Statement:

(Sign in session with counselor)

Please take a moment to review your counselor's "Professional Disclosure Statement." Electronic copies of Professional Disclosure Statements are provided at www.aspenmentalhealth.com under your counselor's bio. Your counselor will also review this statement prior to beginning counseling.

_____

Signature of Client or Guardian **Date**

_____

Signature of Clinician **Date**

Consent For Treatment of Children or Adolescents:

I consent that my child/adolescent 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, unrelated to safety.

_____

Signature of Guardian/Custodian **Date**

Consent to Appointment Reminders (optional):

By signing below, you are agreeing that our office may contact you via phone or 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 receive phone or text reminders, 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: _____

Address/Location of PCP/Person/Entity:_____

Information to be disclosed: _____

Information to be disclosed (ex: all treatment records)

For the purposes of _____

State purpose for disclosure (ex: continuity of care)

Substance Use/Infectious Disease Disclosure:
By selecting "yes" to the following, you are consenting to the release and exchange of information that may include any available ***substance use/abuse or HIV/Infectious disease*** information. Please select "no" if you do not wish for this information to be disclosed**.** ☐ **Yes** ☐ **No**

- By providing your initials, you are indicating that you have understood the above statement and have made your desired selection: _____

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 for one year from the date of signature or until the date specified. Validation of release shall not exceed one year.**

Specified end date: _____ *(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**

_____

Staff Signature **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.

ASPEN mental health

Depression/Anxiety Screen (PHQ-9 & GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores):_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores):_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**