ASCEND PSYCHOLOGICAL SERVICES, PLLC

Rockwell, NC 28138

Demographic Form

Date_____

Client Name: _____Date of Birth: _____

Preferred Name: _____ **Gender** - *Male* *Female* **Marital Status** Married Single Other

Parent/Guardian_____ Relationship _____

Parent/Guardian legal custody papers ___YES __ NO Office will need to make copy of for children under age 18- **BRING TO OFFICE**

Mailing Address _____ Phone – Home #_____

City, State Zip Code_____ Mobile #_____

Email Address:_____

Do you want to receive email and/or text for appointment reminders? *YES* *NO* *EMAIL* *TEXT*

Employer _____ Work # _____

Insurance Provider: _____ Insurance Policy #_____

Policy Holder Name: _____DOB:_____Insurance phone #_____

Name and Contact Information of referring physician (if any): _____

Reason for today's visit: _____

_____

Psychiatric History: _____

_____

Medical History: _____

_____

Medications: _____

_____

Allergies: _____

_____

ASCEND PSYCHOLOGICAL SERVICES, PLLC
110 A East Main Street
P. O. Box 271
Rockwell, NC 28138
Ph: Office - 704-279-0626
Fax: 704-279-0344

Client Rights

- The Confidential handling of records
- Participation in the development of client's treatment plan
- Having an Individualized, written treatment plan within 30 days of admission to Ascend Psychological Services, PLLC
- Having all civil rights, including the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, register and vote, bring civil actions, and marry and get a divorce, unless the exercise of a civil right has been precluded by an unrevoked adjudication of incompetency
- To dignity, humane care, and freedom from mental and physical abuse, neglect, and exploitation
- To treatment, including access to medical care and habilitation, regardless of age or degree of mh/dd/sa disability. To receive necessary treatment for prevention of physical ailments.
- To live as normally as possible while receiving care and treatment and receive age-appropriate treatment for diagnosis. To have opportunities that enable the individual to mature physically, emotional, intellectually, socially, and vocationally to include special education and training in accordance with state and federal law
- To be free for unnecessary medications and for medication not to be used for punishment, discipline, or staff convenience
- Notification that release / disclosure of information may only occur with an authorization or consent unless it is an emergency or for other exceptions as detailed in G.S. or 164.512 of HIPPA
- Right to only release minimum information necessary for coordination of care and services
- Access to a clinician in the case of emergency
- Effective communication while receiving care, treatment, and services, including any complaints about patient care
- The right to consent to or to refuse treatment
- The right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD) to protect and advocate for my rights:

  Phone: 919-856-2195 or 877-235-4210
  Email: info@disabilityrightsnc.org
  Mail: Disability Rights, 3724 Nation Drive, Suite 100, Raleigh, NC 27612
  Fax: 919-856-2244

My signature below verifies that I have read and understand my Client Rights.

_____ _____

Signature Date

ASCEND PSYCHOLOGICAL SERVICES, PLLC
110 A East Main Street
P. O. Box 271
Rockwell, NC 28138
Ph: Office - 704-279-0626
Fax: 704-279-034

Authorization to Disclose Health Information

Client Name: _____ Date of Birth: _____
Client Medical Record #: _____ Client Insurance: _____

I hereby authorize Ascend Psychological Services, PLLC to exchange specific health information from the records of the above named client with

_____

_____

_____

for the specific purpose(s) _____

Specific information to be exchanged: _____

I understand that this authorization will expire on the following date, event, or condition: Client's termination of services with Ascend psychological Services, PLLC.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
Signature of Client	Date	Witness (if required)
_____	_____	_____
Signature of Personal Representative	Date	Personal Representative Relationship/Authority

***Note: this authorization was revoked on: _____ _____
Date Signature of Staff

LPC PROFESSIONAL DISCLOSURE STATEMENT

Renée M. Skey, MA, NCC, LPC
Ascend Psychological Services, PLLC
Office: 704-279-0626
Fax: 704-279-0344
renee@ascendpsy.com

Qualifications:

I graduated from the University of North Carolina at Charlotte (UNCC) in May of 2012 with a Masters of Arts in Counseling, school track. I also obtained a Graduate Certificate in Play Therapy from UNCC. In October of 2011, I passed the National Counseling Exam for Licensure and Certification (#292600). I am currently licensed as a Professional Counselor (#9586) in North Carolina. I also hold a Professional Educator's License in school counseling.

Experience:

My counseling experience includes 2 semesters of internship at Mt. Pleasant Elementary School and one practicum at Northwest Cabarrus Middle School. I have had extensive supervision from my university and site supervisors primarily in Play Therapy. Under supervision, I also led a Child-Parent Relationship Training group, also known as Filial Therapy. I have worked in both a community mental health clinic and a private practice clinic since graduating from UNCC. I am currently employed part-time by the Cabarrus County School System and serve children at Mt. Pleasant Elementary School. The school setting offers me an opportunity provide proactive mental healthcare and help children become the very best they can be. I began seeing clients at Ascend Psychological in November 2017.

Counseling Relationship:

My approach to counseling is based upon "person-centered therapy" developed by Carl Rogers and "Child- centered play therapy" based upon the work of Carl Rogers, Virginia Axline, and Garry Landreth. These are well established, researched, and respected approaches to counseling. I believe that each individual is capable of self- direction and growth. In counseling, I strive to form a relationship with each client, adult or child, which is facilitative to those ends. In the counselor-client relationship, I focus on creating an atmosphere of empathic understanding, acceptance, and genuineness in which the individual is free to become the person he or she chooses to be. When working with children, I use play therapy, making toys and play media available for their use in expression. When working with parents, I use educational techniques and/or Filial Therapy to enable them to better understand their child and their child's expressions through play and thus enhance the relationship with their child.

Session Fees and Diagnosis:

The office fee for an hour session is $189.00. If needed, we can discuss a sliding scale based on hardship at _____ per session. Sessions generally last 45 minutes leaving 10 minutes for consultation with parents or guardians and formation of case notes. We will file insurance for you but you are responsible for paying any co-pays or deductibles at the time of service. Ascend Psychological Services only accepts cash or checks for payment at this time.

Please know that health insurance companies often require that health providers diagnose your mental health condition before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis. Any diagnosis made will become a part of your permanent insurance records.

Cancellation Policy:

Cancellations must be made 24 hours prior to your appointment to 704-279-0626. Failure to do so will result in a $40.00 balance added to your account for failure to cancel for the first time. Subsequent failure to cancel will result in a charge for the full session. If you fail to cancel a 3rd time, you will again be charged the full session fee and are at risk for no longer being able to make an appointment.

Confidentiality:

Communication is confidential, but the following limitations and exceptions do exist: a) if I am using your case records for purposes of supervision; b) if I determine that you or your child are a danger to self or someone else; c) if I am ordered by a court to disclose information; d) if I suspect abuse, neglect, or exploitation of a child, an adult, or elderly person or; e) if you direct me in writing to release your records. (An example of this would be if your child needs special services at school, I may ask that you sign a release so that I may speak with other medical or educational personnel in order to collaborate with them and decide upon the best way to serve your child). You may request to see your case notes at any time.

If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

Emergency Contact Information:

Office phone number is 704-279-0626. Office fax number is 704-279.0344.
Emergency contact: Dr. David Maxwell: 704-202-2056. Email is david@ascendpsy.com
However, Dr. Maxwell and I are often not immediately available. For example, we will not answer the phone when we are with a client. When we aren't unavailable, our telephone is answered by a confidential voicemail. One of us will make every effort to return your call within 24 hours of when you make it, with exceptions of weekends and holidays. If you are difficult to reach, please inform us of a time when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If we will be unavailable for an extend time, we will provide you with the name of a colleague to contact if necessary.

Client Rights and Complaints:

Some clients only need a few counseling sessions to achieve their goals; others may require months or even years of counseling. You may end our or your child's counseling relationship with me at any time. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe may be harmful.

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819 Greensboro, NC
27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblpc.org

Acceptance of Terms:

We agree to these terms and will abide by these guidelines.

Client:_____ Date: _____

Parent (if client is a minor):_____ Date: _____

Counselor:_____ Date: _____

Ascend Psychological Service, PLLC Date _____

Child Intake Form

Childs Name _____Date of Birth_____

About Your Child's Routine

- What kind of physical exercise does your child get? _____
- How much coffee, cola, tea, or other caffeine does your child consume each day?_____
- Is your child's eating restricted in anyway? _____Why? _____
- Sleep: Bedtime _____ Wake Up time _____
- Does your child have any problems getting enough sleep? _____ If yes please explain

  _____

About Your Child's Health

- Who is your child's pediatrician? _____
- Last doctor's visit? _____
- Any Concerns shared by the doctor? _____
- Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has/had

  _____

  _____

  _____
- Allergies _____
- List medications or drugs your child has taken in the last year

  _____

  _____
- List all prior counselors/dates/reasons

  _____

  _____
- Anything else you are concerned about? _____

Other

- Is your child or older sibling in a gang? _____ Has your child or sibling used drugs? _____ If yes, describe which drugs, frequency, age at first use, and

  _____

  _____
- Has this child ever been pregnant or fathered a child? _____

Physical Behavior – check any that are concerns

Aggressive	Failing in school	Lacks respect for authority	Rocking or other repetitive movements
Argues	Fire starting	Learning disability	School avoiding
Assaults	Head banging	Masturbation	Self-harming
Bullies others	Hitting	Mute, refuses to speak	Sexually active
Cheats	Hyperactive	Nightmares	Shy
Complains of feeling sick	Inappropriate sexual behavior	Obedient	Smart-alecky
Cruel to animals	Inattentive	Oppositional	Speech difficulties
Developmental delays	Independent	Picks on others	Stealing
Dropping out of school	Inflicts pain on others	Rages	Temper tantrums
Eating issues	Intimidates others	Recent move	Teases others
	Violent	Uncooperative	Wetting/soiling of bed/clothes

Emotional Behavior – check any that are concerns

Bigoted	Intimidated by others	Negativism	Sexually preoccupation
Bullied by others	Likes to be alone	Nervous	Suicide talk or attempt
Disobedient	Low frustration tolerance	Noncompliant	Teased
Disrupts family activities	Lying	Poor concentration	Unhappy
	Manipulates	Sad	Withdrawn

Any other characteristics or concerns

_____

_____

_____

_____

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