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

Ascend Psychological Services, PLLC
Christopher Lloyd, M.S., Ed.S., LPC
704-773-3514
chrislloyd.counselor@gmail.com

Introduction

I view counseling as a unique and collaborative professional relationship which is built on the foundation of trust. In order to begin the process of building a trusting relationship between us, this document will inform you about my professional background and beliefs, as well as your rights as a client. Providing you with a copy of my professional disclosure statement is a requirement for professional practice as set forth by the North Carolina Board of Licensed Professional Counselors. Please read this document prior to our first session.

Philosophy and Approach

I provide counseling services to children, adolescents, adults and families. The theoretic model of counseling that I utilize is integrated and it includes components and techniques of Cognitive-Behavioral, Adlerian, and Humanistic theories. When providing counseling to children ages 2-10, I may utilize play therapy. Through an actively engaged professional relationship the client and counselor address topics that are intended to lead to an improved quality of life; however, I cannot guarantee such.

Formal Education and Training

I completed an Educational Specialist degree (Ed.S.) with a major in Counselor Education with The University of Alabama in 2012. Additionally, I completed a Master of Science degree (MS) in Counselor Education with East Carolina University in 2009. I am currently licensed in the state or North Carolina as a Licensed Professional Counselor with the license number of 8453. I also maintain licensure as a school counselor with the license number of 1106716.

.

Session Fees and Length of Service

My fees are $150 for the initial intake session (90 minutes), $90 for individual and family sessions (55 minutes), and $50 per hour group session (50 minutes), per group member. A sliding scale is available for clients meeting the annual financial requirement of $20,000 per year for individuals or $35,000 for a family of two or more. This will provide a discount of my regular fees to a percentage of the amount that is more affordable for the client. Cash and Check payments are accepted for all services rendered. Clients will be responsible to provide payment for insurance co-payments. *For returned checks, there will be a $25 charge added to your bill* to cover appropriate banking charges. **Appointment cancellation must be made at least 24 hours prior to the time of the appointment to avoid being charged the full fee of the session.**

Sliding Scale Formula	Annual Income (Individual)	Annual Income (family)	Intake/Individual/Group Rates
	20,000	35,000	140/80/45 per hour
	15,000	30,000	120/60/40 per hour
	10,000	25,000	100/40/25 per hour
	5,000	20,000	90/20/10 per hour
	Less than 5,000	less than 20,000	70/10/5 per hour

Office Hours

My office hours include Monday-Friday evenings from 6:00p.m.-7:30p.m., as well as Saturday from 9:00a.m.-2:00p.m. I may meet with clients outside of the hours listed if circumstance warrant such accommodations.

Confidentiality

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), (c) I am ordered by a court to disclose information, (d) in case of a medical emergency, (e) if you seek reimbursement from a managed care company. These rights are waived if accusations of misconduct are brought about.

Client Rights

All client records are my professional property; however, they are kept on file and are available to you upon written request, if deemed therapeutically valuable. Termination of the therapeutic relationship can be made by you anytime or it can be a collaborative decision between us.

For disability assistance, please contact the Disability Rights of North Carolina at (877) 235-4210 or (919) 856-2195. The fax number is (919) 856-2244 and the email address is info@disabilityrightsnc.org. The physical address is 2626 Glenwood Ave, Suite 550, Raleigh, NC 27608.

Emergencies

If you experience an emergency, which you feel needs to be addressed immediately, please call me at (704) 773-3514. If I do not answer, please leave me a detailed voice message and I will return your call in a timely manner based on the urgency of your concern. If I do not return your call within a few minutes, please call 911 or report to the nearest emergency room.

Procedures for Registering Complaints

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

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

Client Responsibilities

Clients have the responsibility to set and keep their appointments. If you are unable to keep your appointment, please let me know as soon as possible, with at least 24 hours notice. Fees are expected to be paid at the time services are rendered. Treatment plans and goals are a collaborative effort between the counselor and client. As such, the client is expected to follow through with the agreed upon treatment goals. If, at any time, the client refuses treatment or does not follow the instructions of therapy, the client is solely responsible for his/her actions. The client is responsible for being considerate of the rights of other clients, as well as the therapist. The client is responsible for upholding confidential information that is shared by others during the course of group therapy. Lastly, it is the client's responsibility to keep the therapist updated on progress toward treatment plan goals, as well as to inform the therapist about termination before entering into therapy with another clinician.

Consent for Treatment

By signing below, you are indicating that you have read and understand all of the information included in this document. Your signature also indicates that you are giving consent to receive counseling services. Your consent can be revoked at any time per your request.

______________________________ Date ____________

Client Signature

______________________________ Date ____________

Counselor Signature