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
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P. O. Box 271
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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
LPC-A Professional Disclosure Statement
Anya L. Dobbs, MA
Office 704-279-0626
Fax 704-279-0344
E-mail: adobbs@ascendpsy.com

Qualifications

I received my Master's of Science Degree in Professional Counseling in 2011, from South University. I also received a Master's of Science Degree in Applied Psychology in 2016, from Walden University. I have been working in the mental health field since 2006. I am currently licensed as a Licensed Professional Counselor-Associate in the state of North Carolina (#A14285).

Restricted Licensure

I am currently pursing licensure as a Professional Counselor Associate in North Carolina. I am currently under the supervision of an LPC-S as well as a Licensed Psychologist (Dr. David Maxwell of Ascend Psychological Services) as I am currently pursuing my PhD in Clinical Psychology.

Counseling Background

My counseling background consists of experience working with both children, adolescents, and adults in both individual, group, and family settings. I have worked with children, adolescents, and adults in the home, community, school, and psychiatric residential treatment facilities. Areas of treatment include behavioral, personal, relational, emotional, and familial problems.

My theoretical approach varies depending on the needs of the individual, usually taking on an Eclectic approach, but my orientation is mostly Cognitive Behavior Therapy. I also have experience in Person Centered and Reality Therapy. I have used Solution Focused Brief Therapy with individuals who were not receiving long term treatment. I have also been trained in Trauma Focused Cognitive Behavior Therapy. Other techniques that may be used during therapy are role playing, the ABC Model of behavior, and homework.

Session Fees and Length of Service

Counseling sessions will typically last 45-50 minutes unless there are other extenuating circumstances which require more time. The fee for an intake session is $_____. The fee for a standard session is $___. There is a sliding scale for those with financial hardships. If applicable, insurance will be filed for you, but you are responsible for any co-pays or deductibles. Payment is required and expected at the time of services in the form of cash or checks. Failure to submit payment will result in termination of counseling relationship initiated by you and upheld by myself unless otherwise stated and agreed upon with counselor.

Use of Diagnosis

Please note that some health insurance companies will reimburse for counseling services and some will not. In addition, most will require a diagnosis of a mental health condition and indicate that you must have an "illness" before they will agree to reimburse you or pay for services. 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 before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records and client file.

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, or (c) I am ordered by a court to disclose information.

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

Complaints

Although clients are encouraged 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 Ethic http://www.counseling.org/Resources/CodeofEthics/TP/Home/CT2.aspx. Please submit all complaints to

North Carolina Board of Licensed Professional Counselors
PO Box 77819
Greensboro, NC 27417
Phone: 844-622-3572
Fax: 336-217-9450
Email: LPCInfor@ncblpc.org

Complaints related to concerns with services rendered at Ascend can also be discussed with Dr. David Maxwell at 704-279-0626 or david@ascendpsy.com

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: _____