

Miracles Counseling Centers, INC

(P) 704-664-1009/ (F) 704-664-1029

134 Professional Park Dr. St.400
Mooresville, NC 28117

518 Highway 16N
Denver, NC 28037

We are so glad you are here!

Therapist Name: _____

Date: _____

Individual Intake

Client's name: _____

Address: _____ City: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Birthday: _____ SS#: _____ DL#: _____

Emergency Contact: _____ Telephone: _____

Client's Employer/School: _____

Email address: _____

Insurance

Check Type of Insurance: Private Medicaid NC Health Choice EAP None

Insurance Company: _____ Policy Holder: _____

Relationship to Insured: _____ Insured's D.O.B.: _____

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

EAP Authorization Number _____ EAP Phone #: _____

Client Name:

Medicaid #:

Date:

Financial Responsibilities (Please initial)

- Co -payments and deductibles are due at the time of service. _____
- I hereby assign payment of insurance benefits directly to Miracles Healing Centers. While Miracles Healing Centers will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay. _____
- It is my responsibility to inform my therapist of any changes to my insurance coverage. I am financially responsible for any lapses in insurance coverage _____
- While miracles counseling centers will provide me with a courtesy insurance benefits check, I am still responsible for understanding what my insurance covers and verifying this coverage. _____
- It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied I will be responsible for all charges. _____
- I will be billed for phone consultations, letters, or medical record copies at the therapists standard rate by 15 minute increments. _____
- If my portion of the bill is not paid within 90 days from the last date it was incurred a letter will be sent giving you 14 days to pay my account or to arrange for a payment plan. If I do not respond I will be sent to collections. _____
- If accounts are sent to collections, a 25% balance charge will be incurred _____
- Returned check fees are \$35.00 and the check amount. _____
- You will be charged \$75 for missed appointments without providing 24 hour notice of cancellation _____
- Messages regarding appointments may be left on my voicemail. _____ Yes _____ No
- I give permission for text message reminders of my appointments to be sent. _____
- I give permission for email reminders of my appointments to be sent. _____

What brings you to counseling and what goals/skills do you hope to gain?

Strengths Assessment: Please circle all items that you think apply to you.

Family Support	Stable Employment	Religious/Spiritual Community	Participation in Hobbies
Physical Health	Financially Stable	Spontaneous	Creative
Courageous	Forgiving	Enjoys learning	Confident
Exercises	Calm	Fun	Resourceful
Trustworth	Good communication skills	Kind	Accepting
Flexible	Decisive	Organized	Generous
Describe Other Strengths:			

Please check behaviors and symptoms that are of concern to you:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Recurring thoughts | <input type="checkbox"/> Mood shifts |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Withdrawing | <input type="checkbox"/> Sexual addiction | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sick often | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sleeping problems | |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Thoughts disorganized | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Trembling | |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Drug dependence | |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Eating disorder | |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Phobias/fears | <input type="checkbox"/> Memory impairment | |
| <input type="checkbox"/> Other (specify): _____ | | | |

Health Information:

Name of your Primary Care Physician: _____ May we contact? Y/N
Phone number: _____ When were you last seen? _____

Are you receiving care by a Psychiatrist? **Y N** Who?

List all current medications & supplements:

List all current health problems including allergies:

Past psychiatric history hospitalizations (mental health and chemical dependency):

Prior outpatient therapy (include previous practitioners, dates of treatment, previous treatment interventions, response to treatment and/or medications):

Drug and Alcohol Assessment

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office?

Y / N If yes , self / other and their relationship to you _____

Have you ever felt that you should cut down on your drinking? **YES NO**

Have you ever felt bad or guilty about your drinking? **YES NO**

Has anyone in your life asked you to cut down on your drinking? **YES NO**

Have people annoyed you by criticizing you of your drinking? **YES NO**

Do you use any drugs? **YES NO**

Does drug use impact your relationships or work functioning? **YES NO**

Is any kind of substances a method for you in dealing with stress? **YES NO**

Risk Assessment

Have you ever felt suicidal? **YES NO**

Have you ever injured yourself by cutting, hitting, or other means? **YES NO**

Have you ever felt like hurting others? **YES NO**

List a community resource you are currently benefiting: _____

Marital & Family Information:

Married: ____ Divorced: _____ Living together: ____ Separated: _____ Single: _____

If "other" please explain:

List dates and lengths of any previous marriages:

Children's Name & Ages:

Any family history of mental health issues? Describe

Signature of Understanding

Please sign below to indicate that "I have read the above policies, and I understand and agree to comply with them. The information shared is true and accurate. I further agree that I am personally responsible for all financial obligations incurred. I also consent to receive treatment by a Miracles Counseling Centers provider."

Printed Name (or guardian if client is under the age of 18)

Client or guardians Signature

Date

FOR OFFICE USE ONLY

Disclosure Statement signed – Y/N	Insurance card copied- Y/N
CCA completed & signed – Y/N	Treatment Plan completed & signed- Y/N
Intake paperwork with HIPAA & Minor consent form completed & signed – Y/N	Service Request Order signed- Y/N/not applicable
LOCUS/CALOCUS score sheet – Y/N/or not applicable	Release Form to speak with Physician- Y/N/not appl.
Billing Diagnosis is:	For Billing: Consumer is entered into system – Y/N



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Notice of Privacy Practice Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to....

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payments from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that a professional entity has the right to change its Notice of Privacy Practices from time to time and that I may contact that professional at the address above to obtain a current copy of this information.

This facility participates in the North Carolina Health Information Exchange Network, called NC HealthConnex, which is operated by the North Carolina Health Information Exchange Authority (NC HIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from North Carolina programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthConnex not paid for with State funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC HealthConnex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthConnex are available in our offices and online at NCHHealthConnex.gov. You may also contact our Office at (704) 664-1009. Again, even if you opt out of NC HealthConnex, we still will submit your PHI if your health care services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHHealthConnex.gov/patients.

HIPAA Privacy Notification: Email is not a secure method for transmitting confidential information. If you want to make me aware of important information or clinical issues, please call me at 704-664-1009 ext. 22. This message and accompanying documents are covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information intended for the specified individual(s) only. This information is confidential. If you are not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by e-mail, and delete the original message.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Client Name (please print): _____

Signature: _____

Date: _____ Name/Relationship to Client (Please Print) _____

Miracles Counseling Centers, Inc.
Patient Rights and Responsibilities

You have the right to:

- to be treated with dignity and respect
- to fair treatment, regardless of race, ethnicity, reed, religious belief, sexual orientation, gender, age, health statu, or source of payment for cae.
- to have their treatment and oher patient information kept private. Only by lawmay records be released without patient permission.
- to access care easily and in a timely fashion.
- o a candid discussion about all their treatment choices, regardless of cost, or coverage of their benefit plan.
- to share in developing their plan of care.
- to the delivery of services in a culturally competent manner.
- to information about the organization, its providers, services, and role in the treatment process.
- to information about provider work history and training.
- to information about clinical guidelines used in providing and managing their care. to know about advocacy and community groups and prevention services.
- to freely file a complaint, grievance, or appeal, an to learn how to do so.
- to know about laws that relate to their rights and responsibilities.
- to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's right and responsibilities policy.

You have the responsibility:

- to treat those giving them care with dignity and respect.
- to give providers the information they need, in order to provide the best possible care.
- t ask their providers questions about their care.
- t help develop and follow the agreed upon treatment plans for their care, including the agreed upon medication plan.
- to let their provider know when the treatment plan no longer works for them.
- to tell their pvodier about medication changes, including medications given to them by others.
- to keep their appointments. Patients should call their providers soon as possible i thy need to cancel visits.
- to let their provider know about their insurance coverage and any changes to it.
- to let their provider know about problems with paying fee.
- not take actions that could harm others.
- to report fraud and abuse.
- to openly report concerns about quality of care.
- to let their provider know about any changes to their contact information (name, address, phone, etc.)
- understand and help develop plan and goals to improve their health.

I have read and understood my rights and responsibilities.

Client Signature, Date

Client Name:

Medicaid # :

Date:

Credit Card on File Authorization Form

Please note that this form will be securely stored in your clinical file and that you are willing to assume the risk for keeping this information on file.

I authorize Miracles Counseling Centers, Inc., to keep my signature and card information on file and to charge therapy session fees (individual, group, workshops, couples, family or other), or for any appointments with a therapist that are not cancelled within 24 hours of the scheduled appointment time to be charged to my credit, charge or debit card or flex spending account as filled out below for therapy services provided to:

(Therapy Client's Name: Please Print)

I understand that his authorization is valid until canceled in writing. I understand that though this information is secured in my client file, and is unlikely to be tampered with. I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services or materials will normally be posted to my credit/debit/flex card account within 72 hours of each session date. Additionally, I agree that the card listed below may be charged by Miracles Counseling Centers, Inc. in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, CD's DVD's) that I have not returned within one week of termination. I understand that if a charge back fee is incurred or a retrieval fee is incurred I am responsible for these fees. **Initial** _____

Please fill out the details as indicated below:

Card Holders Name:(exactly as it appears on the card)

Card Number _____ C V V _____

Expiration Date _____

Card Type Visa Mastercard Discover American Express Flex

Card Holders Signature _____

Date _____

*******Medicaid clients are exempt from this policy. Medicaid consumers that miss 2 appointments without notice are at risk of being no longer permitted to return to the practice.*******

Signature _____ Date _____