Miracles Counseling Centers, INC
(P) 704-664-1009/ (F) 704-664-1029

111 Kilson Dr. St.201
Mooresville, NC 28117

7480 Waterside Loop Rd. #204
Denver, NC 28037

We are so glad you are here!

Therapist Name: _____ Date:_____

Child/Adolescent Intake

Child's name:_____

Parent/Guardian 1: _____Parent/Guardian 2:_____

Address:_____City:_____Zip:_____

Parent's Telephone: Home:_____ Cell:_____ Work:_____

Date of Birth:_____ SS#:_____ DL#:_____

Emergency Contact: _____Telephone:_____

Child's School: _____

Referred By:_____

Guardian's Email address:_____

DSS Case Management involved in family? □Y □N Case Manager Name:_____

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 #:_____

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. _____

Client Name: Medicaid #: Date:

Consent for Treatment of Minors

1. I (legal guardian name)_____ give my consent to Miracles Healing Centers, Inc. and (therapist) _____, to conduct psychotherapy with (minor name) _____. My relationship to the client is (parent, uncle, guardian, etc.)_____. My signature below indicates that I am notified that all material discussed during psychotherapy sessions is confidential and can be released only with the permission of the minor child.

2. In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs, sex, or high risk behaviors. I will accept (therapist) _____ judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well-being.

3. **To be Completed if Custody Arrangement Exists:**
   It is the responsibility of the consenting parent to inform the other legal parent of the participation in counseling services and its progress. It is also the responsibility of the consenting parent to provide their therapist with the legal custody documentation, as well as advising your counselor of any changes to your custody agreements. I acknowledge I have (please check) ☐ sole legal custody ☐ joint/shared legal custody

In the case of parents who have joint legal custody, please provide the name and contact information of the other parent. Miracles Counseling Centers Counselors believes that it is best clinical practice that an effort is made to connect with both parents. **We understand there are certain circumstances where this may not be appropriate or may not be possible and this can be discussed with your treatment provider.** Please provide the following information of the other parent, if known:

_____

Name Address Phone

Does this parent have (please check) ☐ sole legal custody ☐ joint/shared legal custody?

By signing this, I acknowledge that I have legal custody and that the information I am sharing is true and accurate. My treatment provider has the right to discontinue treatment if information is not provided accurately.**By signing below , I acknowledge my responsibilities and consent to treatment of my minor child:**

_____

Signature (Guardian) Date

_____

Printed Name Relationship Date

What brings you & your child to counseling? What goals/skills do you hope to gain?

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

Family Support	Close Friendships	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:			

Your Child's Symptoms or Problems:

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

___Aggression/Bullying	___ Dating Relationships	___ Phobias/fears
___Antisocial behavior	___ Eating disorder	___ Poor Judgment
___Alcohol use	___ Excessive energy/activity	___ Recurring/Intrusive Thoughts
___Anger	___ Firesetting	___ Running away
___ Impulsivity	___ Loneliness	___ Self-Injury/Head banging
___ Animal Cruelty	___ Learning Disability	___ School Performance
___Anxiety	___ Lying	___ Sibling Relationships
___Attention/focus	___ Hopelessness	___ Sleeping problems
___ Bedwetting/Soiling self	___ Irritability	___ Sexual activity
___Bullying Victim	___ Mood shifts	___ Social Skills
___Depression	___ Nightmares	___ Threats to harm others
___Drug Use	___ Panic attacks	___ Withdrawing from others

Has there been any significant stressors in the family? Please mark "c" for child or "f" for family.

C	F		C	F	
◡	◡	Medical complications	◡	◡	Car accident
◡	◡	Death of a loved one	◡	◡	Parent separation
◡	◡	Frequent moves	◡	◡	Legal problems/Court Involvement
◡	◡	Deployment	◡	◡	New siblings
◡	◡	Change of schools	◡	◡	Parents remarried
◡	◡	Financial stressors	◡	◡	Natural disaster
◡	◡	Divorce	◡	◡	Change in living situation
◡	◡	Significant injuries	◡	◡	Witnessed violence

Developmental History:

Pregnancy and Birth

Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): Please describe:_____

_____

Medications used during pregnancy? Please list:

Smoking? Yes No How much?

Alcohol intake? Yes No How much?

Drug intake? Yes No How much?

Length of pregnancy? ____Weeks Age of mother at birth: Birth weight:

Were there any complications during delivery? If so, please describe:

_____

_____

_____

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over _____ Crawl _____ Stand Alone _____ Walk Alone _____

Toilet trained? **Yes** **No** If yes, days? Nights?

Has your child wet or soiled himself after being trained? **Yes** **No** If yes, until what age? _____

Family Information:

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other_____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:_____

_____

_____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

Any family history of mental health issues? Describe:

_____

_____

_____

<u>Current Health Information</u>:

List all current medications & vitamins:

_____

_____

_____

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:

_____

_____

_____

Name of Primary Care Physician: _____

Phone number: _____ When were you last seen? _____

PT/OT/Speech Therapists? Please Provide Names and Phone Numbers:

_____

_____

_____

List a community resource you are currently benefitting: _____

<u>Risk Assessment</u>

Has this child ever made statements regarding suicidal thoughts or feelings?	**YES**	**NO**
Has this child ever injurred themselves by cutting, hitting, or other means?	**YES**	**NO**
Has this child ever made statements regarding hurting or killing others?	**YES**	**NO**

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

MIRACLES COUNSELING CENTERS, INC

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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 why 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 NCHealthConnex.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 NCHealthConnex.gov/patients.

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, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- to have their treatment and other patient information kept private. Only by lawmay records be released without patient permission.
- to access care easily and in a timely fashion.
- to 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, and 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.
- to ask their providers questions about their care.
- to 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 fees.
- not take actions that could harm others.
- to report fraud and abuse.
- to openly report concerns about the 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 thought 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_____ _

Client Name: Medicaid #: Date: