Rosario Counseling & Associates, PLLC
5909 Falls of Neuse Road Suite 208 Raleigh, North Carolina 27609
Office (919) 649-5882 | Fax (919) 521-8175

DEMOGRAPHIC INFORMATION

Clients Name_____DOB_____

Spouse/Parent(s) Name_____

☐Spouse ☐Parent

Address_____

_____

CONTACT INFORMATION:

Contact # (H) _____ (C) _____ (W) _____

Email_____

Secondary Email If Needed_____

Emergency Contact _____ Phone _____
Relationship _____

INSURANCE INFORMATION:

If Medicare is your primary insurance please see someone in our administrative office, prior to completing this form.

Primary Insurance _____Policy #_____

Primary Policy Holder Name_____

Primary Policy Holders DOB_____

If you have a secondary insurance please bring it to your first appointment, along with your primary card.

PLEASE MAKE SURE WE GET A COPY OF YOUR INSURANCE CARDS

General Information:

Reason for Visit_____

Who referred you to our office? _____

Scheduling Information:

What day of the week works best for your schedule? ☐Mondays ☐Wednesdays ☐Fridays

What time of the day works best for you? ☐Morning ☐Mid-day ☐ Afternoon

Rosario Counseling & Associates

Beth M. Holloway, MA, LPC

5909 Falls of the Neuse Road Ste. 208
Raleigh, NC 27609
(919) 649-5882

Psychological Testing
Adult, Adolescent, and
Child Counseling

Professional Disclosure Statement

Welcome to Rosario Counseling & Associates, PLLC. Counseling is a professional relationship that requires thoughtful consideration. The following information is designed to provide important information that will ensure that you know what to expect from counseling and the therapeutic relationship, my professional services and business policies.
I am a Licensed Professional Counselor, License #9790. I hold a Master's Degree in Professional Counseling from Liberty University. My Undergraduate degree in Psychology is from North Carolina State University

Theoretical Counseling Approach *Client initials* _____
Psychotherapy is not easily described in general statements. It varies depending on the mix of our personalities and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Some of the modalities that I use in therapy are: Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Talk therapy, Interpersonal Psychotherapy, Integrated Spirituality and Faith-Based therapies, Positive Psychology, Creativity therapy, Expressive Arts therapy, and other holistic approaches to psychological treatment. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable and possibly intense emotions. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

If you desire Faith-based Spiritual counseling, I will provide a safe place to explore your spirituality as it pertains to your journey. You may not be sure if you want to discuss your spirituality, and I would want you to feel comfortable to explore or not explore as you see fit. I believe that wellness is holistic, covering the whole person; cognitive, spiritual, emotional, relational and physical. Some of the modalities used in this type of therapy may be prayer/meditation, guided imagery, mindfulness/relaxation/contemplative exercises, inspirational reading, and exploration of distorted core beliefs that are affecting a person's ability to live healthy emotional/spiritual life. Balance is emphasized for holistic healing. Treatment plans are individualized according to your needs. I would be happy to discuss any questions that you may have regarding how I counsel from a Faith -based perspective. You might also take a look at my website (www.rosariocounseling.com) to get more information.

Our initial session is a Diagnostic Child or Adult Interview and will last about 60 minutes. Regular sessions are about 45-60 minutes. The first few sessions will involve a diagnostic evaluation of your needs or your child's needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. I will be happy to help you set up a consultation with another mental health professional for a referral or a second opinion, if you would like. If your situation is beyond my expertise or scope of services, I will assist you in finding appropriate services with another specialist/setting.

Dual Relationships *Client initials* _____
Therapy sessions may be deeply personally psychologically and emotionally; however, keep in mind that we have a professional relationship rather than a social one. You will be best served if our relationship remains professional and if our sessions concentrate strictly on your concerns.

Confidentiality *Client initials* _____

Confidentiality is an essential part of our clinical relationship. Any communication between the counselor and client is part of the clinical record. Our communication will remain confidential with the following exceptions: A). You provide written consent to disclose information to another entity/party, 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. Our office offers a team approach to counseling where it may be appropriate to share your information with another counselor or supervisor within our practice involved in your treatment plan.

Scheduling Appointments, Cancellations, and Length of Sessions *Client initials* _____

Counseling appointments are scheduled in advance. I will make every effort to see you as soon as possible. The length of a counseling session is approximately 60 minutes. When calling to cancel or reschedule, please advise the office at least 24 hours in advance. We maintain a 24 hour, 7 day a week voicemail, thus messages will suffice if you leave the time and date of your cancellation. If the office does not receive advance notice, you may be responsible for paying for the missed appointment.

Fees and Methods of Payment *Client initials* _____

- 60 min Initial Diagnostic Session is **$135** ; 60 mins session is **$110**
- In proven financial hardship, we offer a scholarship or *fee* adjustment based on proven income. To learn more inquire with our office administrator.
- Methods of payment accepted cash, check, benefit cards and credit card.

Billing, Diagnosis and Insurance Reimbursement *Client initials* _____

As a courtesy to our clients our office will file insurance claims for policies that cover outpatient out of network counseling. To determine coverage call the phone number on your insurance card and request to verify benefits. Clients pay the full amount at the beginning of each session and the reimbursement from the insurance company is returned directly to you. If this is a problem please inform me at our initial session. Please remember that you are responsible and not your company for paying the fees agreed upon.

Insurance companies and employee assistance programs often require that I diagnose your mental health condition before they will agree to reimburse you. I will inform you of this diagnosis. Any diagnosis made becomes a part of your insurance record.

Emergency Protocol Client initials _____

In the event of a life-threatening emergency you should immediately call 9-1-1. If you need to speak with a mental health professional while our office is closed, please contact Holly Hill Hospital at (919) 250-7000.

Complaint Procedures *Client initials* _____

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

Client/Counselor Agreement

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

Client: _____ Date: _____

Counselor: _____ Date: _____

Rosario Counseling & Associates, PLLC

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to us. We will maintain the privacy of your health information and we will not disclose your information to others unless you tell us to do so.

A federal law commonly known as HIPAA requires that we take additional steps to keep you informed about how we may use information that is gathered in order to provide health care services to you. As part of this process, we are required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights.

If you have any questions about this Notice please contact our Privacy Officer at (919) 649-5882.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this Notice, please contact us using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. **Treatment:** I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.

2. **Payment:** I may use or disclose PHI so that services you receive are appropriately billed to, and payment collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. **Health Care Operations:** I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. **Required or Permitted by Law:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

B. **Uses and Disclosures Requiring Your Written Authorization**

1. **Psychotherapy Notes:** Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. **Marketing Communications:** I will not use your health information for marketing communications without your written authorization.

3. **Other Uses and Disclosures:** Uses and disclosures other than those described in Section I A above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. **Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. **Right to Alternative Communications.** You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. **Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.

D. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or healthcare operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. **Right to Request Amendment.** You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. **Right to Obtain Notice.** You have the right to obtain a paper copy of this notice by submitting a request to the Privacy Officer at any time.

G. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact the Privacy Officer at (919) 649-5882. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This notice is effective on April 14, 2003.

B. Changes to this Notice. I may change the terms of this Notice at any time. If I change the Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new Notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised Notice by contacting the Privacy Officer.

Rosario Counseling & Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Rosario Counseling & Associates.

_____ _____

Signature of client (or personal representative) Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____

_____

_____

This form will be retained in your medical record.

ROSARIO
COUNSELING & ASSOCIATES, PLLC

OFFICE PAYMENT POLICY:

The following in-office policies have been established to help us continue to provide patients with the best quality care.

OUR OFFICE IS CONSIDERED OUT OF NETWORK. PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED, unless other arrangements have been made prior to the services being rendered. Our office sessions are as follows:

- 60 min session $110
- 45 min session $90

Acceptable forms of payment

- We accept cash, check, Visa, MasterCard, Health Benefits Cards with Visa/MC logo.
- **A $25 processing fee will be charged for all returned checks**. If our office notifies you of a returned check you will be expected to pay the full check amount and NSF fee, prior to their next appointment. We ask that you have another acceptable form of payment available for future appointment, checks will not be accepted.

1. ANY changes to your registration information must be brought to the attention of the office, during check in BEFORE your session. The correct information is critical for billing purposes.

2. If you have insurance, please keep in mind that your insurance is a contract between you and your insurance company. Our office CANNOT guarantee that your carrier will pay your claim. If your claim with your insurance company is denied, the obligation for the payment is the responsibility of the patient. Our office will not enter into a dispute with the insurance carrier over a claim. We will be happy to assist wherever possible.

3. It is our billing policy, to obtain security in the form of your credit card to conveniently pay for possible charges that are outstanding. These possible charges include unanticipated missed appointments, late cancellations, and charges for insufficient funds for checks or credit card payments. Regular payments will be made at each session and you will be able to choose your method of payment for those. All credit card information will be stored securely and confidentially.

4. All cancellations of a therapy session MUST be made within 24 hours of a scheduled session. Failure to do so may result in a full cost of the session fee, which is NOT covered by insurance.

5. In the case of financial hardship, our office will work with the client to arrange a method of payment for services based on our scholarship program criteria.

6. If you are a scholarship recipient and your insurance company makes a payment for your service and the payment is mistakenly sent to you/the patient, instead of the office the patient is expected to submit payment to our office within 10 days of receipt along with the Explanation of Medical Benefit. *This is ONLY applicable for those clients who are participating in our Scholarship Program.*

By signing below, I am indicating that I agree to the above. I also attest that with this financial service contract, I have been given a copy of "Notice of Policies and Practices to Protect Privacy of your Health Information" as is required by law.

Client Signature_____Date _____