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_____DOB_____

☐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 along with your primary card.

Are both above Parties covered under the above insurance ___Yes ___ No If not please list the other insurance plan.

Whose Plan is this? _____

Name of Insurance _____

Policy # _____

General Information: **PLEASE COMPLETE information below:** *Very important information. Thanks*

Reason for Visit_____

How were you referred to our office? _____

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

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

Patient Financial Responsibility Policies

Fees for Services:
Initial session $135
Psychotherapy $110 (53 – 60 minutes)
Psychological test & assessment – cost varies

Non-Sufficient Funds - $25 fee; **Returned Check** - $ 15 fee

Accurate Account Information: I recognize that it is my responsibility to inform Rosario Counseling & Associates PLLC, (hereby known as RCA), of my address, phone number, credit card and insurance information or any changes as long as I remain a client with RCA and/or have an account balance.

Accepted Forms of Payment: Cash, Check, Credit Card (Visa, MasterCard), or Health Benefit/Flex Cards

Responsibility for Payment: I understand and agree that I am responsible to pay charges and balances incurred on my account or the account of my minor child for health care related services provided by RCA. At the time services are rendered payment for services are due to RCA.

Secure Payments: All credit card information is secure through an integrated system allowing for quick confidential payment for services at check-in. In addition patients can pay invoices received through the encrypted patient portal. It is an RCA policy credit card authorization to conveniently pay for charges that are not covered by your insurance carrier. I agree to authorize RCA to use my credit card for outstanding or unpaid balances, unanticipated missed appointments, late cancellations, charges for insufficient funds for checks, and unmet deductibles etc.

Payment for Minor Children/Teenagers services: The accompanying parent or adult of the minor is responsible for full payment at the time service is provided. In the event of divorced or separated parents, please do not place our office in the middle of relationship disputes. I understand and agree to pay in full all charges incurred for the provision of health care and health care related services to my minor child at the time the services are provided.

Insurance Benefits - *deductibles, copays and coinsurance*: I understand I am responsible to provide my current insurance card to RCA, granting permission to bill my insurance company. RCA will collect the estimated amount (deductible, copay or coinsurance) when services are rendered submitting the charges for services to the insurance carrier or third party payer. I understand I am responsible for denied or outstanding balance upon insurance/third party reimbursement. I am responsible to pay my RCA account not insurance.

Authorization for Assignment of Insurance Benefits: I authorize payment of insurance benefits, directly to RCA for services rendered that otherwise would be payable to me.

Missed Appointments/Late Cancellations: I understand that it is my responsibility to provide RCA with 24-hour notice for cancelling an appointment or I may be charged for a missed appointment/late cancellation at the full rate, which is not covered by insurance.

Financial Hardships: If you are in financial hardship and do not have insurance to offset the cost of professional counseling notify the administrative office to determine if you are a candidate for a scholarship.

Testimony: Witness
There will be a charge in the event you subpoena/request a therapist for their testimony as a witness. The fee is $2,640.00 plus a per diem for meals and travel expenses. In addition, fees associated with a hotel stay will be incurred if a hotel is needed when the courthouse is over 45 minutes from therapist's home. All fees must be paid 7 days advanced of court date. These fees are not refundable even in the case of a continuance. These services are not reimbursable through insurance.

Signature of Client: _____ Date:_____