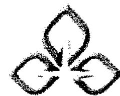
Rosario Counseling & Associates, PLLC

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:

Very important information. Thanks

Reason for Visit____

How were you referred to our office? ____

Rosario Counseling & Associates

Katlyn Davis, MA, LPCA

5909 Falls of Neuse Road, Suite 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 earned a Master of Arts degree in Professional Counseling from Liberty University in Lynchburg, VA, December 2017. I am a Licensed Professional Counselor Associate, License number A13848, supervised by Robin Rosario M.A. LPCS, # S4249. She can be contacted by phone at (919)-649-5882 or email at robin@rosariocounseling.com if you would like to discuss our work with her.

My experience includes providing counseling with children, adolescents, and families as well as working with adults and couples. In addition I have facilitated substance abuse intensive outpatient (SAIOP) groups. Moreover, I incorporated client education to the group therapy process. I coordinated care with outside agencies as well as connected clients to needed resources in the community. My background includes mental health experience providing clinical care in numerous settings and roles.
This has included my role as a program specialist for adults living in a group home. Also, I earned my role as a Team Lead for an Intensive In-home program offering individual and family therapy. Through such invaluable experiences, I have developed effective clinical interventions, case management for clients, their families, and supports within their school and community settings.

Theoretical Counseling Approach *Client initials* _______

My primary therapeutic approach is Person Centered therapy, which engages you as a client in therapy through providing empathy, congruence, unconditional positive regard, acceptance, and reflection of feeling. I also use Cognitive Behavioral Therapy, Motivational Interviewing, and Solution-Focused Therapy. I believe in working from different modalities of counseling in order to better accommodate clients' goals and needs. I provide individual and group therapy. I take a holistic approach to counseling, which promotes healing and improving one's overall well-being by looking at the entire person and their life experiences when assessing and treating clients.

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.

I am a professionally trained to work with clients ranging from those struggling with daily life problems to those suffering a crisis in need of intervention.

Our initial session is a 60-minute Diagnostic Interview, where I will offer you initial impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. We will discuss your desired goals and develop a plan, including frequency of sessions. Your participation is important in working through the challenges you bring to each session. Homework may be assigned to support the counseling process. If your situation is beyond my expertise/scope of services, I will assist you in finding appropriate services. Regular sessions run about 50-60 minutes.

Dual Relationships *Client initials* _______

Therapy sessions may be deeply personal 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 stays professional and if our sessions concentrate strictly on your concerns.

Confidentiality *Client initials* ______

The information you share in the counseling session will be held as confidential as required by the Health Insurance Portability and Accountability Act (HIPAA). All of our communication becomes part of the clinical record. 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. . 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 advanced. I make every effort to see you as soon as possible. The length of a counseling session is 50 to 60 minutes. When calling to cancel or reschedule please advise the office at least 24 hours in advance. I maintain a 24 hour, 7 day a week voice mail 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

Fees and co-pays are due each session unless previous arrangements have bee been made. A $25.00 charge will be made for returned checks.

-60 minute Initial Diagnostic Session is **$135**
-60 minute session is **$110**
-In proven financial hardship, we offer a scholarship or *fee* adjustment based on proven income. To learn more ask our office.
-Payments may be made by cash, check, benefit cards or credit card.

Billing and Insurance Reimbursement *Client initials* _______

As a courtesy to our clients our office will file insurance claims. To determine coverage for an In-Network or Out of Network plan call the phone number on your insurance card and request to verify benefits. Katlyn is in the application stage of being accepted by BCBS of NC however at this time is an out of network provider. **Out of Network** 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.

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. Please remember that you are responsible and not your company for paying the fees agreed upon.

Emergency Protocol *Client initials* ______

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

Ethical Conduct *Client initials* _______

Katlyn practices the ethical standards of her profession as stated by the AACC and ACS. If you are dissatisfied, please Inform Katlyn immediately. If you have a complaint and cannot resolve this problem with Katlyn, you can contact her supervisor Robin Rosario, LPCS at 919-649-5882. If you feel it has not been resolved you may contact the North Carolina Board of Licensed Professional Counselors, PO Box 77819, Greensboro, NC 27417 or call 844-622-3572.

Client/Counselor Agreement

Please sign and date this form, indicating you understand and accept the content herein. The office will provide a copy to you. If you have any questions/concerns regarding the professional disclosure statements please ask prior to signing this document.

______________________ ______________________
Clients Signature *Date*

______________________ ______________________
Legal Guardian (of minor) *Date*

______________________ ______________________
Therapist Signature *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:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- 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: __________