Nature’s Way Holistic Counseling

Karen McKinney, LCMHCA

# Client Consent and Intake Record Form

Date:

Client Name(s): \_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_

(if under 17 years of age)

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

## Authorization to Contact Client

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby grant permission to contact me/us at the below listed phone numbers and email address (if listed) in regards to counseling appointments or billing questions.

Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_cell / work / home (Okay to leave msg?) \_\_\_Yes \_\_\_No

Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_cell / work / home (Okay to leave msg?) \_\_\_Yes \_\_\_No

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you check this email account regularly? Y N

Date:

Signature:

Signature: (Partner- if coming as a couple)

**Emergency Contact Information:**

Contact Name: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone:

**Client Information:**

Sex: M F Other\_\_\_\_­\_\_\_\_\_ Couple

Age: Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ School grade (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_

Name of School (if currently or recently enrolled):

Marital/Relationship Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently Employed? Y N If yes, Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Counseling: Y N If yes, When: Where: \_\_\_\_\_\_\_\_

Have you ever been hospitalized for mental health reasons? Y N

If yes, When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Problem:

(Reason for seeking counseling)

Goal/s for therapy (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent / Guardian Consent for Services**

**(if client is under age of 17)**

Client Name:

I, , being the parent or legal guardian of the above mentioned

individual, who is under the age of 17 and has applied for services from Nature’s Way Holistic Counseling, PLLC, do hereby certify that these services are being provided with my full knowledge and consent. I understand that to withdraw my consent I must notify this office in writing. I also waive my right to see the notes and ask about the personal things shared between my child and the therapist for the sake of creating emotional and relational safety in the therapeutic relationship.

Parent or Guardian Signature:

Date:

Current Symptom Checklist (Check all that apply within the past 90 days)

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol Abuse | Depression | Irritability | Recent Loss |
| Anger/Explosiveness | Difficulty Concentrating | Job/School Problems | Risk Taking |
| Anxiety | Excessive Energy | Legal Problems | Self-Injury |
| Avoidance | Excessive Exercise | Loss of Interest | Sexual Abuse |
| Bingeing/Purging | Excessive Guilt | Low Self-Esteem | Substance Abuse |
| Change in Appetite | Family Conflict | Marital/Relationship Problems | Suicidal Actions |
| Change in Libido | Fatigue | Panic Attacks | Suicidal Thoughts |
| Change in Sleep | Financial Concerns | Physical Abuse | Suspiciousness |
| Communication Issues | Forgetfulness | Physical Pain | Traumatic Event |
| Compulsive Gambling | Gastrointestinal Problems | Phobia | Verbal/Emotional Abuse |
| Crying | Impulsivity | Racing Thoughts | Other: |

Notice of Privacy Practices

This notice describes your rights regarding your health information. All information revealed by you in a counseling or therapy session and most information placed in your counseling/therapy file is considered “protected health information” by the Health Insurance and Portability and Accountability Act of 1996 (HIPPA). This law established a national baseline of patient’s rights to confidentiality and requires that we give you this notice of privacy practices. As such, your health information cannot be distributed to anyone else without your informed and voluntary written consent or authorization. There are exceptions as delineated in your consent for treatment document.

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private to you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have a right to ask us to limit what we tell people involved in your care or the payment of your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law or in an emergency or when the information is necessary to treat you.
3. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy from the Privacy Officer.
4. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the healthcare we provide to you in any way.
5. As a client you have the right to receive a history of all disclosures of protected health information. You may be required to pay copying fees.

If you have any questions regarding this notice of the Health Information Privacy Policies, please contact your therapist.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and understand this Notice of Privacy Practices, and have been given sufficient information regarding any questions I have had concerning its contents.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Partner - if coming as a couple)

This document is designed to inform you concerning my background and to insure your understanding of our professional relationship.

Qualifications

Karen’s highest degree is a master’s degree in clinical mental health counseling with a specialization in trauma and crisis counseling. The degree was received in December 2020 and granted by Walden University, a CACREP program. Karen has two years of counseling experience.

Counseling Background

Karen has served a variety of clientele in North and South Carolina in outpatient, residential, and intensive in-home community-based settings. She has worked with clients from all socio-economic backgrounds, as well as court-ordered clients, children and teens. She has worked with clients presenting a range of issues, such as anxiety, depression, post-traumatic stress disorder, bipolar disorder, trauma, marriage and family conflict, substance use disorders, department of juvenile justice youth, children in foster care, the LGBTQ+ community, and more. Her primary theoretical orientation is cognitive behavioral therapy (CBT), although Karen considers herself an eclectic counselor utilizing research proven techniques and interventions from multiple theories based on each client’s individual needs. She also utilizes techniques from dialectical behavioral therapy, trauma-focused CBT, play therapy, and motivational interviewing.

Confidentiality

All information shared in therapy sessions is always confidential. All our communication becomes part of the clinical record, which is accessible to you upon request. 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/neglect), or (c) I am ordered by a family or criminal court of law to disclose information. I engage in weekly professional supervision with a licensed clinical counselor supervisor to continually improve my own work. The supervision is confidential; however, as some current cases are discussed, I will divulge as little of your personal identifying information as possible.

Appointments/Cancellations

You can contact the office at IVY Integrative to schedule, reschedule or cancel an appointment at (704) 569-5489 or online at ivyintegrative.com under Book Now- Karen McKinney. I am often unavailable to answer the phone, but I try to return all calls received during the work week within 36 hours. **I do not text with clients.** In the event that you will not be able to keep a scheduled appointment, you must notify me at least 24 hours in advance. If canceling an appointment scheduled for a Monday, you must cancel by the time of your appointment on the previous Friday. **Clients who contact me with less than 24 hours’ notice will be charged a late cancellation fee of $45, and clients who miss an appointment with no notice at all will be charged a $60 missed appointment fee.**

Session Fees and Lengths of Service:

Initial Assessment/Evaluation Session (90 Minutes): $130

Subsequent Sessions (50 Minutes): $100

Phone or Online Sessions (50 Minutes): $100

Late Cancellation (Less than 36 hours): $45

Missed Appointment (No show): $60

Telephone consultations are no charge for the first ten minutes but $10 for every ten-minute segment thereafter. Calls over thirty minutes will be billed the same as an individual session. Preparation of required documents or letters and notes are subject to additional fees. These fees are based on time spent and correlate to my hourly rate of $100.

Use of Diagnosis

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an “illness” before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Insurance

I am not in the practice of filing insurance for my clients. **All fees must be paid at the time of service.** However, if you would like to submit the claim to your insurance yourself, you may request an official receipt that will include a diagnosis and billing code. Clients are encouraged to seek preapproval with their insurance before starting therapy in order to ensure the highest rate of reimbursement.

Payment of Accounts

**Payment is expected at the time of service.** Cash, checks, and credit cards are accepted. All returned checks will be turned over to the Solicitor’s Worthless Check Unit.

Therapeutic Relationship

Although our sessions will be based on honesty, it is important for you to realize that we have a professional rather than personal relationship. Our contract will be limited to the paid sessions that you have with me. Please do not invite me to social gatherings, offer me gifts, friend me on social media, send me text messages or photos, or ask for me to relate to you in a personal way outside of our counseling sessions. While there may be times when you experience me in the community, you will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

It is impossible to guarantee any specific results regarding your counseling goals. However, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards and with the code of conduct established by the American Counseling Association’s *Code of Ethics* and the North Carolina Board of Examiners for Licensed Professional Counselors. A copy of these codes is available upon request at https://www.ncblpc.org, or by mail to 7 D Terrace Way, Greensboro, NC 27403 or by phone at [(336) 217-6007](https://www.google.com/search?q=nc+board+of+counselors&rlz=1C1CHFX_enUS737US737&oq=nc+board+of+counselors&aqs=chrome..69i57j46i175i199i512j0i22i30l2j69i60.6734j0j15&sourceid=chrome&ie=UTF-8).

Complaints

In the event that you are dissatisfied with my services for any reason or have questions regarding the counseling relationship, please let me know so we can discuss it and give it the opportunity to be addressed. 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 Clinical Mental Health Counselors   
P.O. Box 77819

Greensboro, NC 27417  
Phone: 844-622-3572 or 336-217-6007  
Fax: 336-217-9450  
E-mail: [Complaints@ncblcmhc.org](mailto:Complaints@ncblcmhc.org)

Acceptance of Terms

I/We have read and understand all the information listed above and give my consent for treatment. I agree to these terms and will abide by these guidelines.

**Please sign and date this form**

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Printed Name

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Printed Name (If couple)

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Signature

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Signature (If couple)

Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_