CareNet Counseling
An affiliate of Wake Forest Baptist Health

Highland Office:
114 Highland Avenue
Fayetteville, NC 28305
Phone: 910.484.0176
Fax: 910.484.5781

Westmont Office:
805 Westmont Drive
Fayetteville, NC 28305
Phone: 910.484.4061
Fax: 910.484.4069

www.fayfamlife.org

Fayetteville Family Life Center

Faith-Based & Community Family Counseling Center

Client Name _____

Case Number _____

ADULT CLINICAL HISTORY

Please answer these questions as completely as possible.

YOUR MARRIAGE: Present marital status: ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Living Together**

How many times have you been married? _____

#	Dates	Spouse's Name	Reason for Termination
1.			
2.			
3.			

YOUR CHILDREN: Number of children List your children and indicate if the child is a stepchild or adopted.

YOUR PARENTS:

Mother		Age	Living	☐Yes	☐No
Cause of death		Health	☐Good	☐Fair	☐Poor
Residence		Occupation			
Father		Age	Living	☐Yes	☐No
Cause of death		Health	☐Good	☐Fair	☐Poor
Residence		Occupation			
Stepparents		Age	Living	☐Yes	☐No
Cause of death		Health	☐Good	☐Fair	☐Poor
Residence		Occupation			

YOUR SIBLINGS: Please list all brothers and sisters from oldest to youngest. Include yourself in the list. Indicate if the sibling is half or adopted.

#	Name	Age	Location	Occupation
1.				
2.				
3.				

YOUR BLOOD RELATIVES: (including aunts, uncles, cousins) who have experienced emotional problems, depression, problems with drugs or alcohol, or been treated by a psychiatrist:

#	Name	Relation	Problem
1.			
2.			
3.			

Is there anyone in your family who has a history of violent behavior, suicide, multiple arrest or prison terms?

#	Name	Relation	Problem
1.			
2.			
3.			

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ADULT HEALTH INFORMATION

Circle appropriate answer			**Do not write in the spaces below**
Do you feel sad or blue most of the time?	Yes	No	
Has your appetite changed?	Yes	No	
Do you have crying spells?	Yes	No	
Do you have trouble sleeping?	Yes	No	
Do you have feelings of hopelessness?	Yes	No	
Do you think about hurting or killing yourself?	Yes	No	
Do you think about hurting or killing another person?	Yes	No	
Do you feel anxious, nervous, or stressed much of the time?	Yes	No	
Have you ever been so anxious that you had trouble breathing?	Yes	No	
Are you deathly afraid of anything (snakes, thunderstorms, animals, heights, etc.)?	Yes	No	
Do you sometimes picture things in your mind that disturbs you and are not related to a realife problem?	Yes	No	
Is there anything that you do (checking locks, washing hands, cleaning things, etc.) more than other people?	Yes	No	
Do you worry all the time?	Yes	No	
Do you ever have times you feel unusually good or do impulsive things?	Yes	No	
Have you ever seen or heard something that might not be there?	Yes	No	
Do you ever think or believe things that others say are not possible or real?	Yes	No	
Do you smoke?	Yes	No	
Do you drink alcohol?	Yes	No	
Do you use recreational drugs?	Yes	No	
Have you had a DUI?	Yes	No	
Have others (family, doctor, employer) expressed concern about your smoking, drinking, or using drugs?	Yes	No	
Were you abused in any way as a child	Yes	No	
Have you ever experienced any type of unexpected, traumatic event?	Yes	No	
Do you have religious beliefs and thoughts that affect your living?	Yes	No	

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CONFIDENTIAL INFORMATION

Please fill out this confidential information form carefully and completely. This information will be used by your counselor to assist you.

Client Date of Birth	**Age**	**Email Address**	
Last Name	**First Name**		**MI**
Address		**City/State**	**ZipCode**
Hm Phone		**Wk Phone**	**Cell**

CLIENT OR RESPONSIBLE PARTY

Employer Name	**Occupation**	
Address	**City/State**	**ZipCode**
Email		

Party responsible for payment, if other than client		*Annual Family Income*	*Military Status*	*Clergy Status*
Name		☐ Less than 10,000	☐ Active Duty	☐ Active
Address		☐ 10,000 – 19,000	☐ Retired	☐ Retired
		☐ 20,000 – 29,000	☐ Reserve	☐ Spouse
City/St/Zip		☐ 30,000 – 39,000	☐ Spouse	☐ Dependent
Phone		☐ 40,000 – 49,000	☐ Dependent	
Date of Birth	**Social Sec. #**	☐ 50,000 – 59,000		
		☐ 60,000 – 69,000		
		☐ 70,000 – 79,000	☐ More than $80,000	

Client Sex: ☐ **Male** ☐ **Female**	**Race**:	
Denomination or religious preference:	**Local church/Congregation**:	
Marital status: ☐ **Single** ☐ **Engaged** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widow(er)**		
Highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+		
Personal physician or group practice:		
Current medications:		
In case of emergency, please notify:	**Phone**	**Relation**
Previous counselor or therapist:		

How did you hear about us? ***Please check all that apply.***				
☐ Telephone Book	☐ Yellow Pages	☐ Attorney	☐ School System	☐ Insurance Co.
☐ EAP Referral	☐ Physician	☐ Brochure	☐ Friend/Family	☐ Other:
☐ Radio	☐ Television	☐ Minister	☐ Newsletter	
☐ Social Services	☐ Newspaper/Media	☐ Former Client	☐ Website	
Would you like to receive free mailings from the center? ☐ Yes ☐ No				

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Charges and Payment Information

The charges and payment expectations for services you receive at the center will be established with your counselor at the first session. Payment is expected at the time of service. The center accepts cash, checks, MasterCard, and Visa. Should you have any questions or concerns regarding the charges or payment requirements, please talk with your counselor or the office manager immediately. Faithfulness in the payment of fees becomes an important part of the therapy experience. Payments on account are due upon receipt of the monthly statement. Overdue accounts may result in formal collection procedures.

Cancellations and Missed Appointments

Clients are requested to give a minimum 48-hour notice when canceling an appointment. Appointments cancelled with less than 24-hours notice or appointments missed without notice are subject to charge. Unless otherwise specified, your medical record will be terminated 75 days from the last date of contact with the client.

Insurance Coverage

The center will assist you in filing for insurance benefits for covered services. If you intend to apply for insurance coverage, please present insurance policy information or a current insurance identification card at the reception area prior to your session. A photocopy of your insurance information will be made to ensure that eligibility of coverage can be verified and that accurate claims can be filed. Complete the following information only if you request the center to file your insurance claims.

Primary Insurance:			
Name of Ins. Co.			
Ins. Co. Phone No.			
Address of Ins. Co.			
Certificate or Policy No.			
Group No.		Group Name	
Policyholder's Name			
Policyholder's DOB			
Policyholder's SS#			
Relation to Policyholder			

Secondary Insurance:			
Name of Ins. Co.			
Ins. Co. Phone No.			
Address of Ins. Co.			
Certificate or Policy No.			
Group No.		Group Name	
Policyholder's Name			
Policyholder's DOB			
Policyholder's SS#			
Relation to Policyholder			

Client Consent

I have received and read the center's statement of client/patient rights. I have read and understand the center's policy on charges, insurance filing, payment expectations, cancellations, and missed appointments. I agree to and accept financial responsibility for payment for services received. In the event I use insurance benefits to pay all or a portion of the charges, I hereby authorize the release of any medical information necessary to process insurance claims filed on my behalf. I hereby assign payment of insurance benefits to this CareNet counseling center: I acknowledge that I am financially and legally responsible for the full payment of charges for services received in the event my health insurance claims are denied.

_____ _____

Client Signature *Date*

_____ _____

Signature of Responsible Party (if other than Client) *Date*

OFFICE USE ONLY

Individual pay or co-pay $_____ Pay $_____ per _____

Primary Diagnosis _____ Secondary Diagnosis _____

Counselor Signature _____ Date _____

Facility _____

OFFICE USE ONLY

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CLIENT RIGHTS

- Right to be treated well and have your privacy respected, and freedom from mental and physical abuse, neglect, exploitation, retaliation or humiliation.
- Right to live as normally as possible while receiving care and treatment.
- Right to culturally competent treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disability or substance abuse.
- Right to a personalized and culturally appropriate service plan that focuses on your goals, needs and abilities, strengths, preferences, and cultural background and needs.
- Right to receive a copy of your treatment plan at any time during your treatment. If you would like to receive a copy of your treatment plan, your counselor will provide you one.
- Right to have this plan in place within 15 days of admission to Fayetteville Family Life Center/CareNet Counseling.
- Right to exercise the civil rights available to all citizens unless these rights have been limited by a court of law.
- Right to confidentiality. This means no one has access to your identity or health information without your written permission, except in special situations that are defined in the Notice of Privacy Practices and Consent to Treat.
- Right to services that are best suited for your age, level of need, and cultural background.
- Right to be completely informed in advance of the potential risks and benefits of different service choices.
- Right to be free from unnecessary medication.
- Right to consent to or refuse any service you have been offered unless: (a) in an emergency situation, (b) if service was ordered by the court, (c) you are under 18 years old, and your legally responsible person gives permission, even if you object. Refusal or expression of choice may pertain to service delivery, release of information, concurrent services, and composition of the service delivery team and/or involvement in research projects, if applicable.
- Right to contact Disability Rights NC.

Disability Rights NC
3724 National Drive,
Suite 100, Raleigh, NC 27612
Toll-Free: 877-235-4210
TTY: 888-268-5535
Fax: 919-856-2244

NC Division of MH/DD/SAS
Advocacy and Customer Service
3009 Mail Service Center
Raleigh, NC 27699
1-919-715-3197
Toll-Free: 1-855-262-1946

By signing below you are confirming you have read and understand the information above.

Client Printed Name: _____

Client Signature: _____ Date: _____

Legally Responsible Party

Printed Name *(if required)* _____

LRP Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

If you are unsure how to appeal changes to your services or if you have questions about appeals, you can contact the director of the FFLC, Robbie Byrd at (910) 484-0176 or the COO of CareNet Counseling, Bryan Hatcher at (336) 716-0858. FFLC/CareNet Counseling staff strives to resolve complaints as quickly as possible.

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Client Name:_____ Chart Number: _____

OUTPATIENT SERVICE AGREEMENT

FAYETTEVILLE FAMILY LIFE'S COUNSELING SERVICES

Counseling is not easily described in general statements. It varies depending on the personality of the counselor and client and the particular problems which concern the client. There are a number of different approaches which can be utilized to address the problems you bring to counseling. One factor which makes this practice unique is our attention to spiritual as well as emotional and interpersonal issues. Our counselors are persons of faith. For those who consider spirituality significant, we integrate that aspect of your life into counseling so that your relationship with God can be used as a resource in the process of treatment. However, we will not attempt to change your religious beliefs or to promote any particular religious faith.

Any counseling requires a very active effort on your part. In order to be most successful you will have to work both during your sessions and outside them. Counseling has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings or recalling unpleasant aspects of your history. Counseling, though, has been shown to have benefits for people who undertake it. By the end of your first visit here, your counselor will be able to offer you some initial impressions of what your work will include and an initial treatment plan. You should evaluate this information along with your own assessment about whether you feel comfortable working with your counselor. If you have questions at any time, you should discuss them whenever they arise.

MEETINGS

Our normal practice is to conduct an evaluation which will take place in your first session. During this time, your counselor can decide whether s/he is the best person to provide the services which you need in order to help you meet your treatment objectives. If counseling is initiated, we will usually schedule a follow up appointment. Appointment times usually last 40-45 minutes, although sometimes sessions will be longer. The frequency of sessions will be decided between you and your counselor. Once an appointment time is scheduled, you will be expected to keep it unless you provide 48 hours advance notice of cancellation. Should you not give us adequate notice or fail to keep an appointment you will be charged $75 (unless your counselor agrees that you were unable to attend due to circumstances beyond your control). You will need to pay this fee before another appointment will be scheduled. Repeated late cancellations or missed appointments will result in the termination of therapy.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have health insurance that provides mental health coverage, it is important that you supply us with your insurance information so that we can verify coverage as it applies to your counseling sessions. If there is insurance coverage for your therapy we will file the necessary claim forms. However, if for any reason, your insurance company does not pay the claims, you are responsible for full payment of all fees. It is also your responsibility to pay for all annual deductibles as dictated by your policy. You should also be aware that all insurance agreements require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary or in some cases a copy of the entire record. This information will become part of the insurance company files. You will be asked to sign an authorization to release this information.

PROFESSIONAL FEES, BILLING AND PAYMENTS

The Fayetteville Family Life Center provides therapy for clients regardless of financial circumstances. The standard fee is charged whenever insurance is available or when family income warrants. Otherwise, fees are adjusted between client and counselor, based on client's ability to pay. Our hourly fees are $95-$155 per therapy hour depending upon the credentials of the therapist. You will be expected to pay for each session at the time it is held unless we agree otherwise or you have insurance coverage which requires another arrangement. The particulars of your fee will be discussed during the initial session. In addition, it is our practice to charge for certain other activities such as school meetings and court appearances. In the event that you become involved in some litigation and we are required to give testimony, you agree to pay for the professional time required even if we are compelled to testify by another party. Because of the complexity and difficulty of legal involvement, we charge our regular hourly rate for preparation and attendance at any legal proceeding (fee adjustment does not apply). If you ever have questions about your fee or balance please ask anytime. Fees may be paid by check, cash, or credit card. We will file all appropriate insurance claims. You are expected to pay the insurance deductible within the first few sessions and the copay weekly unless other arrangements are made in advance. There is a $25 returned check charge. We will work with you to make the counseling affordable whatever your financial resources. Once a fee is set, however, we expect you to pay for the services. If you ignore your fees and do not honor your payment plan with us, we reserve the right to turn the account over to a Medical Collections Service.

PROFESSIONAL RECORDS

We are required to keep appropriate records of your treatment. These records are the property of Fayetteville Family Life Center. You may purchase copies of your records for your personal use or another party in accordance with our policy on record copying. Copies of your records will be sent to another party only with your written permission.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is our policy to request an agreement from parents that they consent to give up access to your records. If they agree, we will provide them only general information on how your treatment is proceeding unless we feel that there is a high risk that you will seriously harm yourself or another, in which case we will notify them of our concern. Before giving them information we will discuss the matter with you and will do the best we can to resolve any objections you may have about what we are prepared to discuss.

CONTACTING YOUR COUNSELOR

Office hours are 9am-7pm Monday thru Thursday. We are closed on Fridays. When someone is unavailable you may leave a message on the answering machine or in the case of an emergency contact our answering service at 1-800-249-6439. Your counselor or the on-call counselor will call you back.

TERMINATION OF COUNSELING

Clients and/or counselors may terminate counseling in any one of the following ways:

(1) Client and counselor mutually determine that counseling goals have been adequately met.
(2) Client and/or counselor determine that counseling is not progressing satisfactorily and the process should be discontinued. In this case, the counselor can assist the client in finding a new counselor if this is the client's desire.
(3) Client has not seen the counselor in 90 days and there has been no prior agreement to keep the case open.

When counseling is terminated there is no longer a counseling relationship between client and counselor, and the traditional obligations of client and counselor no longer exist.

ETHICS

We are committed to providing our clients with competent, professional counseling services conducted according to the highest ethical standards. All of our counselors ascribe to the codes of ethics governing the licenses in their professions. If at any time you feel that your counselor is acting in an unprofessional or unethical manner, you are urged to contact the Director of the Fayetteville Family Life Center. If you do not receive a satisfactory response you may write to the President, Baptist Hospital, CareNet Counseling Centers, PO Box 573001, Winston-Salem NC 27157.

CONSENT FOR TREATMENT

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Your signature also indicates that you are consenting to treatment provided by the professionals of Fayetteville Family Life Center in accordance with all applicable agency policies and all state and federal laws.

I have read the above information and I agree to the terms of this contract.

_____ _____

Signature of Client/Parent/Guardian *Date*

_____ _____

Signature of Counselor *Date*

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The Fayetteville Family Life Center as a part of CareNet Counseling Centers of Wake Forest Baptist Health has adopted Wake Forest Baptist Health's Privacy Practices.

The Wake Forest Baptist Health Notice of Privacy Practices states how we may use and release your health information. By signing below, you (or your legal representative) agree that you have been offered the opportunity to review the Wake Forest Baptist Health Notice of Privacy Practices, which has been revised as of July 1, 2016.

_____

Printed Name

_____ _____

Signature *Date*

FOR WFBH USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

_____

_____

_____