

Palmetto Counseling & Consulting Services, LLC

Client Information

Client Date of Birth _____ SS# _____ Today's Date _____
Gender _____ Ethnicity _____ Marital Status _____
Client First Name _____ MI _____ Client Last Name _____
Client Address _____ City _____ State _____ Zipcode _____
Client Phone _____ Office Phone _____ Cell Phone _____
Client Email _____ Ok to leave message? _____ Yes _____ No
Ok to contact via email? _____ Yes _____ No (note: Check 'yes' if you would like to receive appointment reminders via email.
Palmetto Counseling will not use your email address for marketing, sales, or provide to outside entities).

Client Employer _____
Client Employer Address _____ City _____ State _____ Zipcode _____
Employer Phone # _____ Employed _____ Full Time _____ Part
Time _____ Retired _____ Disabled _____ Unemployed _____ Homeless _____ Student _____ Other

Client Driver's License # _____ Last School Attended (if Minor) _____
Current Grade (if Minor) _____ Name of Psychiatrist (if applicable) _____
Name of Primary Care Physician /Practice: _____
Current Medications & Dosage: _____
Active Medical Problems: _____ Known Allergies (Drug, Food, Seasonal) _____
Previous Treatment or Counseling? If so, identify provider(s), date(s), diagnosis, and problem(s) addressed:

Presenting Problem(s) / Reason for Today's Office Visit:

List of Family Members / Others / Physicians, etc., involved in Client's Treatment [for HIPAA Consent to Release Protected Healthcare Information on behalf of client]

Legal Guardian (if applicable) _____ Custody Mother Father Joint Other

Mother's Name (if minor) _____ Father's Name (if minor) _____
Please provide copies of Court/Custody Papers (if applicable)

Emergency Contact _____ Relation _____
Emergency Contact Address _____ City _____ State _____ Zipcode _____
Emergency Contact Phone # _____

Name of Person / Practice who referred you / How did you hear about us? _____

Policy Holder's Information

[Please Bring Your Insurance Card and Co-pay Fees to Your Appointment]

Policy Holder's First Name _____ MI _____ Policy Holder's Last Name _____
Policy Holder's Date of Birth _____ SS# _____
Policy Holder's Address _____ City _____ State _____ Zipcode _____
Policy Holder's Phone _____ Office Phone _____ Cell Phone _____
Policy Holder's Email _____ Ok to leave message? _____ Yes _____ No

Ok to contact via email? Yes No (note: Check 'yes' if you would like to receive appointment reminders via email. Palmetto Counseling will not use your email address for marketing, sales, or provide to outside entities).

Policy Holder's Employer _____ **Driver's License #** _____
Policy Holder – Employer Address Address _____ **City** _____ **State** _____ **Zipcode** _____

Insurance Plan Name _____
Insured's ID# _____ **Insured's Group Policy#** _____
Amount of Co-pay \$ _____ **Insurance Cust. Service #** _____

Secondary Insurance (Complete only if Applicable)

Policy Holder's First Name _____ **MI** _____ **Policy Holder's Last Name** _____
Policy Holder's Date of Birth _____ **SS#** _____
Policy Holder's Address _____ **City** _____ **State** _____ **Zipcode** _____
Policy Holder's Employer Phone # _____
Policy Holder's Phone _____ **Office Phone** _____ **Cell Phone** _____
Policy Holder's Email _____ **Ok to leave message?** Yes No
Ok to contact via email? Yes No (note: Check 'yes' if you would like to receive appointment reminders via email. Palmetto Counseling will not use your email address for marketing, sales, or provide to outside entities).

Policy Holder's Employer _____ **Driver's License #** _____
Policy Holder's Employer _____ **Driver's License #** _____
Policy Holder – Employer Address Address _____ **City** _____ **State** _____ **Zipcode** _____
Policy Holder's Employer Phone # _____

Secondary Insurance Plan Name _____ **Insured ID#** _____ **Group Policy#** _____
Amount of Co-pay \$ _____ **Insurance Cust. Service #** _____

I understand that I am financially responsible for all deductibles, co-pays and missed appointments, or appointments cancelled without 24-hour notice. I confirm that the above information is accurate and complete, to the best of my knowledge. I also understand that if I do not inform Palmetto Counseling & Consulting Services, LLC of changes in my insurance coverage before services are rendered, I will be financially responsible for payment in full. I am also responsible for informing Palmetto Counseling & Consulting Services, LLC of any changes in my address, phone number, and emergency contact information.

Client / Parent / Legal Guardian (if applicable) _____ Date

Client / Parent / Legal Guardian (if applicable) _____ Date

Staff Witness _____ Date

Palmetto Counseling & Consulting Services, LLC

Consent to Treatment

I agree to take part in psychotherapy/counseling at Palmetto Counseling & Consulting Services, LLC. I understand that developing a treatment plan and regularly reviewing our work and goals is in my best interest. I agree to play an active role in the process.

I understand that psychotherapy/counseling has potential risks and benefits. I understand that no promises or guarantees have been made to me as to the results or success of treatment.

I also understand that I may withdrawal from treatment at any time. Withdrawal of consent can be in any form: verbal, active resistance, repeated noncompliance, or any other unwillingness to continue participating in treatment. If I withdraw consent I will be responsible for paying for the services that I have already received.

I acknowledge that if I must cancel an appointment, I must cancel within 24 hours of the appointment. If I do not cancel or fail to show, I may be charged for the full charge of the missed appointment. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR FINDING A NEW THERAPIST IF I FAIL TO SHOW FOR TWO CONSECUTIVE APPOINTMENTS WITHOUT PROVIDING 24-HOUR NOTICE. PALMETTO COUNSELING WILL NOT CONTINUE TO PROVIDE SERVICE AFTER TWO NO-SHOWS.

My signature below shows that I understand and agree with all of the above statements. The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions. **If the client is a minor or has a legal guardian appointed by the court, the client's parent(s) or legal guardian(s) appointed by the court, the client's parent(s) or legal guardian(s) must sign this consent and provide copies of Court/Custody Papers (if applicable).**

Printed Name Date

Client / Parent / Guardian Signature Date

Staff Witness Date

Coordination with Primary Care Physician or Psychiatrist (if applicable)

It may be beneficial for our practice confer with your Primary Care Physician or Psychiatrist (if applicable) with regard to your mental health treatment. In addition, some Managed Care Plans require that we notify your physician/ psychiatrist by telephone or in writing concerning mental health services, unless you request that notification not be made. This information will not be released without your consent, except in an emergency.

Please check one of the following:

___ **I do** authorize Palmetto Counseling & Consulting Services, LLC to contact my Primary Care Physician or Psychiatrist whose name and address are shown below to discuss the diagnosis, treatment plan, and prognosis while under Palmetto Counseling & Consulting Services, LLC care. In addition, Palmetto Counseling & Consulting Services, LLC is authorized to obtain information from my Primary Care Physician or Psychiatrist concerning my medical diagnosis and treatment.

___ **I do not** authorize Palmetto Counseling & Consulting Services, LLC to contact my Primary Care Physician or Psychiatrist whose name and address are shown below to discuss the diagnosis, treatment plan, and prognosis while under Palmetto Counseling & Consulting Services, LLC care. I am providing Palmetto Counseling & Consulting Services, LLC with the name and address of my Primary Care Physician or Psychiatrist for informational purposes only.

Primary Care Physician / Psychiatrist _____

Telephone() _____ **City** _____ **State** _____ **Zip Code** _____

Client / Parent / Guardian Signature Date

Staff Witness Date

Anxiety Symptoms

- Excessive / uncontrollable worry about events or activities (such as work or school performance).
- Feeling on edge or keyed up
- Worry excessively about acting / speaking more aggressively than you should
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- Is afraid of being around other people
- Has fear of performing
- Tries to avoid social situations (If unavoidable, feels awful)
- Fear interferes with (sleep, school, activities)
- Feels very uncomfortable because of fear
- Feels that behavior does not make sense (e.g., “why do I have to worry about this when it seems like other people don’t”)
- Phobic object/situation:

When confronted with object/situation,

- Gets uptight and scared, can’t move
- Cries, clings to parents, throws tantrums
- Avoids object/situation
- Becomes nauseated, feels faint
- Fear interferes with (sleep, school, activities)
- Feels super uncomfortable because of fear
- Is more scared of object/situation than peers
- Fear seems silly to person

Panic Disorder

- Feelings of panic / panic attack
- Fear of going out (due to anxiety of panic attack)
- Feeling numb, unreal, or as if detached from one’s body
- A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:
 - ↑ Heart rate
 - Sweating
 - Shaking
 - Sensations of shortness of breath or smothering
 - Feeling of choking
 - Chest pain or discomfort
 - Nausea or Abdominal distress
 - Feeling dizzy, unsteady, lightheaded, or faint
 - Derealization (feelings of unreality) or depersonalization (being detached from oneself)
 - Fear of losing control or going crazy
 - Fear of dying
 - Paresthesias (numbness or tingling sensations)
 - Chills or hot flashes

Posttraumatic Stress Disorder (PTSD)

- Exposure to threats of death or serious injury, or subsection to actual injury, that resulted in an intense emotional response of fear, helplessness or horror
- Intrusive, distressing thoughts or images that recall the traumatic event
- Disturbing dreams associated with the traumatic event
- A sense that the event is recurring, as in illusions or flashbacks
- Intense distress when exposed to reminders of the traumatic event
- Physiological reactivity when exposed to internal or external cues that symbolize the traumatic event
- Avoidance of activity, places, or people associated with traumatic event
- Avoidance of thoughts, feelings, or conversations about the traumatic event
- Inability to recall some important aspect of the traumatic event
- Lack of interest and participation in formerly meaningful activities
- A sense of detachment from others
- Inability to experience the full range of emotions, including love
- A pessimistic, fatalistic attitude regarding the future
- Sleep disturbance
- Irritability or angry outbursts
- Lack of concentration
- Hyper-vigilance or feeling on edge
- Exaggerated startle response
- Symptoms have been present form more than one month

Conduct Disorder / Delinquency

- ___ Persistent refusal to comply with rules /expectations in home, school, or community
- ___ Excessive fighting, intimidation of others, cruelty or violence toward people or animals, and destruction of property
- ___ History of stealing at home, at school, or in the community
- ___ School adjustment characterized by disrespectful attitude toward authority figures, frequent disruptive behaviors, and detentions or suspensions for misbehavior
- ___ Repeated conflict with authority figures at home, at school, or in the community
- ___ Impulsivity as manifested by poor judgment, taking inappropriate risks, and failing to stop and think about consequences of actions
- ___ Numerous attempts to deceive others through lying, conning, or manipulating
- ___ Consistent failure to accept responsibility for misbehavior accompanied by a pattern of blaming others
- ___ Little or no remorse for misbehavior
- ___ Lack of sensitivity to the thoughts, feelings, and needs of other people
- ___ Multiple sexual partners, lack of emotional commitment, and engaging in unsafe sexual practices
- ___ Use of mood-altering substances on a regular basis
- ___ Participation in gang membership and activities

Attention-Deficit / Hyperactivity Disorder

- ___ (Adults) Childhood history of ADHD that was diagnosed or later concluded due to the symptoms of behavioral problems at school, impulsivity, temper outbursts, and lack of concentration.
- ___ Unable to concentrate or pay attention to things of low interest, even when those things are important to his/her life.
- ___ Often fails to give close attention to details or make careless mistakes in work or other activities
- ___ Often has difficulty sustaining attention in tasks
- ___ Often does not follow through on instructions and fails to finish duties in the workplace
- ___ Often has difficulty organizing tasks and activities
- ___ Has experienced significant impairment in social, academic, or occupational functioning
- ___ Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
- ___ Often interrupts or intrudes on others
- ___ Often easily distracted by extraneous stimuli
- ___ Often loses things necessary for tasks or activities
- ___ Disorganized in most areas of his/her life
- ___ Starts many projects, but rarely finishes any
- ___ Often forgetful in daily activities
- ___ Impulsive; has an easily observable pattern of acting first and thinking later
- ___ (Adults) Tendency toward addictive behaviors
- ___ Often restless and fidgety; unable to be sedentary for more than a short period of time
- ___ Often experiences feelings of restlessness in situations in which it is inappropriate
- ___ Often has difficulty engaging in leisure activities quietly
- ___ “Often on the go” or often acts as if “driven by a motor”
- ___ Often talks excessively
- ___ Has a “low boiling point and a short fuse”
- ___ Often blurts out answers before questions have been completed
- ___ Often has difficulty awaiting turn
- ___ Exhibits low stress tolerance, is easily frustrated or upset

Anger Management Problems

- ___ History of explosive aggressive outbursts out of proportion to any precipitating stressors, leading to assaultive or destruction of property.
- ___ Over-reactive hostility to insignificant irritants
- ___ Swift and harsh judgment statements made to or about others
- ___ Body language of tense muscles (e.g., clenched fist or jaw) glaring looks, or refusal to make eye contact
- ___ Use of passive-aggressive patterns (e.g., social withdrawal, lack of complete or timely compliance in following directions or rules, complaining about authority figures behind their backs, nonparticipation in meeting expected behavioral norms) due to anger.
- ___ Expressions of anger that include threats, destroying property, breaking objects, invading other’s personal space, and refusing to speak to others (who they are mad at).
- ___ Intimidation and use of coercion to get one’s way
- ___ Hostile, aggressive behavior that alienates friends, family, neighbors, and others
- ___ Expressions of anger that are perceived by others as demeaning, threatening, or disrespectful
- ___ Use of abusive language

<p><u>Psychoticism</u></p> <p>___ Bizarre thought content (delusions of grandeur, persecution, reference, influence, control, somatic sensations, or infidelity)</p> <p>___ Illogical form of thought or speech (loose association of ideas in speech; incoherence; illogical thinking; vague, abstract, or repetitive speech; neologisms; perseverations; clanging)</p> <p>___ Perception disturbance (hallucinations, primarily auditory but occasionally visual or olfactory)</p> <p>___ Disturbed affect (blunted, none, flattened, or inappropriate)</p> <p>___ Lost sense of self (loss of ego boundaries, lack of identity, blatant confusion)</p> <p>___ Diminished volition (inadequate interest, drive, or ability to follow a course of action to its logical conclusion; pronounced ambivalence or cessation of goal-directed activity)</p> <p>___ Relationship withdrawal (withdrawal from involvement with the external world and preoccupation with egocentric ideas and fantasies; alienation feelings)</p> <p>___ Poor social skills (misinterpretation of the actions or motives of others; maintaining emotional distance from others; feeling awkward and threatened in most social situations; embarrassment of others by failure to recognize the impact of own behavior)</p> <p>___ Inadequate social control over sexual, aggressive, or frightened thoughts, feelings, or impulses (blatantly sexual or aggressive fantasies; fears of impending doom; acting out sexual or aggressive impulses in an unpredictable and unusual manner, often directed toward family and friends)</p> <p>___ Psychomotor abnormalities (a marked decrease in reactivity to the environment; various catatonic patterns such as stupor, rigidity, excitement, posturing, or negativism; unusual mannerisms or grimacing)</p>	<p><u>Grief / Loss Unresolved</u></p> <p>___ Thoughts dominated by loss coupled with poor concentration, crying spells, and confusion about the future.</p> <p>___ Serial losses in life (i.e., deaths, divorces, jobs) that led to depression and discouragement</p> <p>___ Strong emotional response exhibited when losses are discussed</p> <p>___ Lack of appetite, weight loss, and/or insomnia as well as other depression signs that occurred since the loss</p> <p>___ Feelings of guilt that not enough was done for the lost significant other, or an unreasonable belief of having contributed to the death of the significant other</p> <p>___ Avoidance of talking on anything more than a superficial level about the loss</p> <p>___ Loss of a positive support network due to a geographic move</p>	<p><u>Sexual Abuse</u></p> <p>___ Vague memories of inappropriate childhood sexual contact that can verified by significant others.</p> <p>___ Self-report of being sexually abused with clear, detailed memories.</p> <p>___ Inability to recall years of childhood</p> <p>___ Extreme difficulty becoming intimate with others</p> <p>___ Inability to enjoy sexual contact with a desired partner</p> <p>___ Unexplainable feelings of anger, rage, or fear when coming into contact with a close family relative</p> <p>___ Pervasive pattern of promiscuity or the sexualization of relationships.</p>
<p><u>Low Self-Esteem</u></p> <p>___ Inability to accept compliments</p> <p>___ Makes self-disparaging remarks; sees self as unattractive, worthless, a loser, a burden, unimportant; takes blame easily.</p> <p>___ Lack of pride in grooming</p> <p>___ Difficulty in saying no to others; assumes not being liked by others.</p> <p>___ Fear of rejection of others; especially peer group</p> <p>___ Lack of any goals for life and setting of inappropriately low goals for self</p> <p>___ Uncomfortable in social situations, especially larger groups</p>	<p><u>Type A Behavior</u></p> <p>___ A pattern of pressuring self and others to accomplish more because there is never enough time</p> <p>___ A spirit of intense competition in all activities</p> <p>___ Intense compulsion to win at all costs regardless of the activity or co-competitor</p> <p>___ Inclination to dominate all social or business situations, being too direct and overbearing</p> <p>___ Propensity to become irritated by the action of others who do not conform to own sense of propriety or correctness</p> <p>___ A state of perpetual impatience with any waiting, delays, or interruptions.</p> <p>___ Difficulty in sitting and quietly relaxing or reflecting</p> <p>___ Psychomotor facial signs of intensity and pressure (e.g., muscle tension, scowling, glaring, or tics)</p> <p>___ Psychomotor voice signs (e.g., irritatingly forceful speech or laughter, rapid and intense speech, and frequent use of obscenities)</p>	<p><u>Vocational Stress</u></p> <p>___ Feelings of anxiety and depression secondary to interpersonal conflict (perceived feelings of inadequacy, fear, and failure) secondary to severe business losses</p> <p>___ Fear of failure secondary to success or promotion that increases perceived expectations for greater success</p> <p>___ Rebellion against and/or conflicts with authority figures in their job</p> <p>___ Feelings of anxiety and depression secondary to being fired or laid off, resulting in unemployment</p> <p>___ Anxiety related to perceived or actual job jeopardy</p> <p>___ Feelings of depression and anxiety related to complaints of job dissatisfaction or the stress of employment responsibilities.</p>

<p><u>Marital / Couples Conflict</u></p> <p>___ Marital difficulties lead to arguments and disagreements, causing ongoing erosion of the marital and family relationship</p> <p>___ Partners are alienated from each other, which places tension on the family unit.</p> <p>___ Frequent or continual arguing with partner</p> <p>___ Lack of communication with partner</p> <p>___ A pattern of angry projection of responsibility for the conflicts onto the partner.</p> <p>___ Involvement in multiple intimate relationships at the same time.</p> <p>___ Physical and/or verbal abuse in a relationship</p> <p>___ A pattern of superficial or no communication, infrequent or no sexual contact, excessive involvement in activities (work or recreation) that allows for avoidance of closeness to the partner.</p> <p>___ A pattern of repeated broken, conflicted relationships due to personal deficiencies in problem solving, maintaining a trust relationship, or choosing abusive or dysfunctional partners.</p>	<p><u>Marital / Couples Conflict (Continued)</u></p> <p>___ Talk of separation sparks fears and concern among various family members, causing them to compensate in various ways (e.g., parentification or overindulgence).</p> <p>___ Parents decide to separate, giving rise to questions about which family members remain in the home and who should leave.</p> <p>___ Children are in a loyalty conflict over being separated from one parent and from their siblings</p> <p>___ Parents decide to separate and/or divorce, but remain under the same roof, which contributes to coldness and estrangement in the home.</p> <p>___ Financial difficulties arise as the result of operating two separate households and this restricts family members' amenities.</p>	<p><u>Marital / Couples Conflict (Continued)</u></p> <p>___ Symptoms of anxiety, depression, or acting-out behaviors (substance use, poor school performance, etc) develop in family members.</p> <p>___ Child management problems develop as a result of single parenting and lack of support from ex-spouse.</p> <p>___ Children assume some responsibility and guilt for the marital failure.</p>								
<p><u>Chemical / Alcohol Dependence</u></p> <p>___ Self-report of almost daily use of alcohol or illicit drugs or regularly using until intoxicated</p> <p>___ Consistent use of alcohol or other mood-altering drugs until high, intoxicated, or passed out.</p> <p>___ Amnesic blackouts occur when abusing alcohol.</p> <p>___ Inability to stop or cut down use of mood-altering drug one started, despite the verbalized desire to do so and the negative consequences continued use brings.</p> <p>___ Blood work that reflects the results of a pattern of heavy substance use (e.g., elevated liver enzymes)</p> <p>___ Denial that chemical dependence is a problem despite direct feedback from spouse, relatives, and employers that the use of the substance is negatively affecting them and others.</p> <p>___ Increased tolerance for the drug as evidenced by the need to use more to become intoxicated or to attain the desired effect.</p> <p>___ Changing peer groups / friends to one that is noticeably oriented toward regular use of alcohol and/or illicit drugs</p> <p>___ Suspension of important social, recreational, or occupational activities because they interfere with using the mood-altering drug.</p> <p>___ Drug paraphernalia and/or alcohol found in client's possession or in his/her personal area (e.g., bedroom, car, etc)</p> <p>___ Marked change in behavior (e.g., isolation or withdrawal from family and close friends, loss of interest in activities, low energy sleeping more)</p> <p>___ Physical withdrawal symptoms (shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, and / or depression).</p>	<p><u>Chemical / Alcohol Dependence [continued]</u></p> <p>___ Continued substance / alcohol use despite persistent physical, legal, financial, vocational, social, or relationship problems that are directly caused by the substance/ alcohol use.</p> <p>___ Frequent Mood swings</p> <p>___ Problems at work / school due to excessive absenteeism, lateness</p> <p>___ Poor self-image as evidenced by describing self as a loser or a failure, and rarely making eye contact when talking to others.</p> <p>___ Predominantly negative or hostile outlook on life and other people.</p> <p>___ Has been arrested for possession, driving under the influence, or drunk and disorderly charges.</p> <p>___ Positive family history of chemical / alcohol dependence.</p> <table border="1" data-bbox="649 1365 1120 1680"> <tr> <td><input type="checkbox"/> C</td> <td>Have you ever felt that you should Cut down on your drinking?</td> </tr> <tr> <td><input type="checkbox"/> A</td> <td>Have people Annoyed you by criticizing your drinking?</td> </tr> <tr> <td><input type="checkbox"/> G</td> <td>Have you ever felt bad or Guilty about your drinking?</td> </tr> <tr> <td><input type="checkbox"/> E</td> <td>Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye-opener)</td> </tr> </table>	<input type="checkbox"/> C	Have you ever felt that you should Cut down on your drinking?	<input type="checkbox"/> A	Have people Annoyed you by criticizing your drinking?	<input type="checkbox"/> G	Have you ever felt bad or Guilty about your drinking?	<input type="checkbox"/> E	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye-opener)	
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Palmetto Counseling & Consulting Services, LLC (“Palmetto”)

Name:	DOB:	Date:
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Dear Client:

It is our goal to provide quality care to you and your family at a reasonable cost.

Please be mindful that your appointment time is reserved **exclusively** for you and be considerate of others – if you miss your appointment or cancel at the last minute, we will be unable to provide care for another client in your place, and have no way of recovering lost revenue due to “no-shows” or last-minute cancellations. As a courtesy (and with your permission), Palmetto Counseling can send you an appointment reminder via email to help you keep track of your upcoming appointments.

‘No shows,’ late cancellations, or un-paid fees for services delivered are a significant expense for providers. Over time, this translates to lost revenue and drives up operating costs; which forces providers to increase professional fees to make up for that loss.

At Palmetto Counseling, we believe that our primary focus and attention should be on providing you and your family with optimal care (not spending unnecessary amounts of time, focus, and energy on patient billing and unpaid accounts).

As part of the registration process, it is our policy that new clients complete the Credit Card Authorization Form attached to the Financial Policy, which permits Palmetto Counseling to bill your credit card for the charges and fees that you would have incurred had you attended your appointment should you fail to provide 24 hour advance notice, change, or appear for your appointment. This fee is non-refundable and is **not** covered by your insurance or EAP.

Please know that your credit card / financial information will be held securely and this information is confidential (as are your medical records) until your insurance has paid their portion and provide verification via an Explanation of Benefits (EOB) to our practice as well as you, the client, how much, if any, is your portion.

PALMETTO COUNSELING PAYMENT POLICY

Initial _____ If you are not insured, payment in full is expected at time of service. Our services are charged as follows:

- **Comprehensive Clinical Assessment / Diagnostic Interview - \$160**
- **Individual Therapy (45 – 50 minutes) - \$110.00**
- **Family Therapy - \$130.00 per hour**
- **Couples / Marital Therapy - \$130.00 per hour**

Initial _____ **First Appointment:** Please arrive for your initial appointment a few minutes early so that all paperwork may be completed before you see the clinician. Please bring your current insurance card with you EACH VISIT. On follow-up visits, you will be asked to verify demographic/insurance information so that our records remain up-to-date. Please be prepared to pay for the current visit as well as any past balances on your account. Payment of co-pays, deductibles or any non-covered services will be required at the time of service. Paying applicable co-pays/deductibles/co-insurance charges at the time of service does not mean that you will not receive a bill after your visit, fees are only estimated. For your convenience, we accept CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS, AND DEBIT.

Initial _____ **Insurance:** When scheduling an appointment at our practice, it is your responsibility to confirm with your insurance company that the clinician is under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral in hand at the time of your appointment. If your insurance should happen to change, we require that you notify our office 24 hours prior to your appointment time. If you do not notify us (before the date services are rendered) of any changes in your insurance coverage, **YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.**

Initial _____ **Proof of Insurance.** Patient must provide correct insurance information at time of service. Failure to do so may result in a \$10 rebilling charge.

Initial _____ **Co-pays:** Co-pays are due at the time of service. A \$10 billing charge may be added to cover billing expenses if not paid at the time of service.

Initial _____ **Client is responsible for knowing their benefit coverage for specialist visits.** We will be happy to file your insurance claim on your behalf. We allow 45 days from date the claim was filed for your insurance company to pay. If your insurance does **NOT** pay within this time, you may be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and / or policy benefit criteria (e.g., deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or reasonable and customary charges, etc) other than to supply factual information when necessary.

Initial _____ **Out-of-Network Insurance & Insurance Denials:** If you have insurance that our practice does not accept or claim is denied by your insurance company, you will be responsible for the full amount of all professional fees and charges for services provided. We can provide you with a receipt for clinical services rendered that you may submit to your insurance company for reimbursement.

Initial _____ **If you are insured by a managed care organization (HMO),** and are being seen for any covered service, you must have **PRIOR AUTHORIZATION.** If you do not obtain authorization, you will be responsible for **PAYMENT IN FULL.** We suggest that

you contact the customer service number on your insurance card prior to your first visit to determine if prior authorization is required as well as basic information regarding your behavioral health benefits.

Initial _____ **Any Preferred Provider (PPO) or In-Network discounts will not apply UNLESS YOU HAVE YOUR INSURANCE CARD WITH YOU.** If you do not have your insurance card with you, insurance has instructed us to collect payment in full for all services received. In the event your insurance carrier informs us your eligibility status has changed, you will be responsible for payment in full until verification of insurance benefits is obtained from your insurance carrier.

Initial _____ **Usual and Customary Rates:** Palmetto is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Initial _____ **You are responsible for deductibles, co-insurance, non-covered services, and any other charges your insurance may not cover.** You will be sent monthly statements regarding any monies owed by you, the client. If the same balance becomes more than 3 months past due, you will be charged a finance charge of \$10.00 each month thereafter until the balance is paid in full. If your account should ever have to be turned over to a collection agency, all discounts will be removed and a \$25 collection processing fee will be added to the account. Additional fees may be added if the account is not paid within 45 days of being placed in collections. Credit bureaus are advised of unpaid debt.

Initial _____ **Collections: Accounts will be sent to collections after 90 days if not paid as agreed.** If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require our practice, as allowed by law, to disclose confidential information about you. You agree that if we must collect on your account that you will be responsible for the costs of collection, including attorneys' fees. In most collection situations, the only information our practice would release regarding a client's treatment is his/her name, the type of services provided, and the amount due [If such legal action is necessary, these costs will be included in the claim].

Initial _____ There will be a **\$40 charge for all returned checks with insufficient funds.**

Initial _____ **Missed Appointments and Late Cancellations:** Please be mindful that your appointment time is reserved **exclusively** for you and be considerate of others – if you miss your appointment or cancel at the last minute, we will be unable to provide care for another client in your place, and have no way of recovering lost revenue due to “no-shows” or last-minute cancellations. Therefore, it is our policy that new clients complete the Credit Card Authorization Form, which permits Palmetto to bill your credit card for the charges and fees that you would have incurred had you attended your appointment should you fail to provide 24 hour advance notice, change, or do not show for your appointment. Please know that your credit card / financial information will be held securely (as are your medical records) until your insurance has paid their portion and provide verification via an Explanation of Benefits (EOB) to our practice as well as you, the client, how much, if any, is your portion.

Initial _____ **Palmetto charges the full session fee for non-insured clients and the *contracted / discounted rate for insured / EAP clients** for missed appointments or appointments cancelled / rescheduled with less than 24 hours advance notice (*Note: excludes the following: Aetna EAP, Corp Care EAP, Business Health Services EAP, Managed Health Network HMO / EAP / TriCare North, ComPsych EAP, and Deer Oaks EAP clients or in the case of emergency situations). This fee is non-refundable and is **not** covered by your insurance or EAP.

Initial _____ **Administrative Fees:** Similar to other medical practices, declining insurance reimbursements and rising costs force us to charge for certain administrative services. The following fees are generally applicable to new patients and are **not** covered by insurance:

- Disability Claims, Forms, Reports, & Letter Completion (completed outside of appointment times): \$40 - \$75 based on number / length of time required to complete
- Telephone Consult / After-Hours Consult with Clinician - \$25 (per 15 minutes or portion thereof)
- E-mail Consult with Clinician - \$40 per issue / e-mail
- Medical Record Copying Fees: 10 pgs & up - \$15 flat fee + \$.65 / pg; Under 10 pgs \$.65 / pg

Thank you for understanding the reason behind these fees. We will be reasonable in applying them and notify you when they apply.

Palmetto Counseling & Consulting Services, LLC ("Palmetto") Financial Policy		
Name:	DOB:	Date:

- If you are not insured, payment in full is expected at the time of service. Our general services are charged as follows:
 - **Comprehensive Clinical Assessment / Diagnostic Interview - \$160**
 - **Individual Therapy (45 – 50 minutes) - \$110.00**
 - **Family Therapy - \$130.00 per hour**
 - **Couples / Marital Therapy - \$130.00 per hour**
- Insurance: Payment of fees & charges must be paid in full if your insurance company does not pay. Your insurance policy is a contract between you and your insurance company. We will not become involved in disputes between you & your insurance company regarding deductibles, co-payments, etc. other than to supply factual information as necessary. In the event our practice is unable to accept assignment of benefits under your health insurance plan, we require that you provide us with a credit card with authorization to bill the card for the balance of our fees if necessary.
- Proof of Insurance. Patient must provide correct insurance information at time of service. Failure to do so may result in a \$10 rebilling charge.
- Co-pays: Co-pays are due at the time of service. A \$10 billing charge may be added to cover billing expenses if not paid at the time of service.
- Usual and Customary Rates: Palmetto is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Any Preferred Provider (PPO) or In-Network discounts will not apply UNLESS YOU HAVE YOUR INSURANCE CARD WITH YOU. If you do not have your insurance card with you, insurance has instructed us to collect payment in full for all services received. In the event your insurance carrier informs us your eligibility status has changed, you will be responsible for payment in full until verification of insurance benefits is obtained from your insurance carrier.
- If you do not notify us (before the date services are rendered) of any changes in your insurance coverage, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.
- If you have insurance that our practice does not accept or claim is denied by your insurance company, you will be responsible for the full amount of all professional fees and charges for all services or any non-covered services provided. We can provide you with a receipt for clinical services rendered that you may submit to your insurance company for reimbursement.
 - If your insurance company has not paid claims submitted to your account in full within 60 days, you will receive an invoice for the unpaid balance; which may be transferred to your credit card in the event of non-payment. Please be aware that some and perhaps all of the services provided may not be covered and not considered reasonable / necessary under your insurance plan. If you are insured by a managed care organization (HMO), and are being seen for any covered service, you must have PRIOR AUTHORIZATION. If you do not obtain authorization, you will be responsible for PAYMENT IN FULL. We suggest that you contact the customer service number on your insurance card prior to your first visit to determine if prior authorization is required as well as basic information regarding your behavioral health benefits. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT IF YOUR INSURER FAILS TO PAY FOR OUR SERVICES WITHIN 60 DAYS, FOR ANY REASON.**
- Late Payment & Collection Policy: All services must be paid within 60 days of service unless the delay is because of an insurance filing error from our practice. Any payment received from the insurance company after the patient has paid the practice will be reimbursed to the patient up to the amount paid by the patient.
- Late & Partial Payment Administration Fees: \$5 after 30 days of the first invoice sent and \$25 after 30 days of the second invoice being sent. Partial payments are not accepted unless previously agreed. A \$5 administrative charge will be applied to partial payments.
- Collections: Accounts will be sent to collections after 90 days if not paid as agreed. All discounts will be removed and a \$25 collection processing fee will be added to the account. Additional fees may be added if the account is not paid within 45 days of being placed in collections. Credit bureaus are advised of unpaid debt.
- Missed Appointments and Late Cancellations: Please be mindful that your appointment time is reserved exclusively for you. Please be considerate of others – if you miss your appointment or cancel at the last minute, we will be unable to provide care for another client in your place, and have no way of recovering lost revenue due to “no-shows” or last-minute cancellations. Therefore, it is our policy that new clients complete the Credit Card Authorization Form below, which permits Palmetto to bill your credit card for the charges and fees that you would have incurred had you attended your appointment should you fail to provide 24 hour advance notice, change, or appear for your appointment. Please know that your credit card / financial information will be held securely (as are your medical records) until your insurance has paid their portion and provide verification via an Explanation of Benefits (EOB) to our practice as well as you, the client, how much, if any, is your portion.
- Administrative Fees: Similar to other medical practices, declining insurance reimbursements and rising costs force us to charge for certain administrative services. The following fees are generally applicable to new patients and are not covered by insurance:
 - Disability Claims, Forms, Reports, & Letter Completion (completed outside of appointment times): \$40 - \$85 based on number / length of time required to complete
 - Telephone Consult with Clinician - \$25 (per 15 minutes or portion thereof)
 - E-mail Consult with Clinician - \$40 per issue / e-mail
 - Medical Record Copying Fees: 10 pgs & up - \$15 flat fee + \$.65 / pg; Under 10 pgs \$.65 / pg
- Thank you for understanding the reason behind these fees. We will be reasonable in applying them and notify you when they apply.*

CREDIT CARD AUTHORIZATION FORM

I authorize Palmetto to charge outstanding client balances as well as any charges and fees for me and my dependents should you fail to provide 24 hour advance notice, change, or appear for your appointment to the following credit card.

Client Name: _____
(Printed Full Name) Please Print Legibly

Card Holder Name: _____
(Printed Full Name of Card Holder as it appears on credit card) Please Print Legibly

Billing Address: _____
(As it appears on your credit card statement) Please Print Legibly

Card Holders Telephone # as listed with card company: _____ **CSCCode:** _____
Please Print Legibly (3 digit security code listed on back of card)

Card # _____ **Expiration Date** _____

Type (Please Check One)

- Visa
- Master Card
- Discover
- American Express

Signature of Authorization to Charge - Must be Legible (Date)

Note: There will be a **\$40 charge for all returned checks with insufficient funds**. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require our practice, as allowed by law, to disclose confidential information about you. You agree that if we must collect on your account that you will be responsible for the costs of collection, including attorneys' fees. In most collection situations, the only information our practice would release regarding a client's treatment is his/her name, the type of services provided, and the amount due [If such legal action is necessary, these costs will be included in the claim.]

I understand that Palmetto charges the full session fee for non-insured clients and the *contracted / discounted rate for insured / EAP clients for missed appointments or appointments cancelled / rescheduled with less than 24 hours advance notice (*Note: excludes the following: Aetna EAP, Corp Care EAP, Business Health Services EAP, Managed Health Network HMO / EAP / TriCare North, CompPsych EAP, Deer Oaks EAP clients or in the case of emergency situations). This fee is non-refundable and is **not** covered by your insurance or EAP.

I agree to allow Palmetto to bill my credit card for any missed appointments or late cancellations that I may have. I understand that Palmetto will provide me a copy of my credit card receipt for my records. I further understand that this policy in no way will compromise my ability to dispute a charge or question my insurance company's determination of payment.

YOU UNDERSTAND THAT YOU ARE RESPONSIBLE FOR FINDING A NEW THERAPIST IF YOU FAIL TO SHOW UP FOR TWO CONSECUTIVE APPOINTMENTS, WITHOUT PROVIDING A 24 HOUR NOTICE. WE WILL NOT CONTINUE TO PROVIDE SERVICE AFTER TWO NO-SHOWS. I HAVE READ AND AGREE TO THE ABOVE POLICY TERMS.

(Signature of Responsible Party) (Date)

I hereby assign, transfer and set over to Palmetto all my rights, title, and interest to my medical reimbursement benefits under my insurance policy and authorize Palmetto to file (and assign to Palmetto my right to file) my insurance claim under my policy for Palmetto's services. I further authorize the release of any medical information needed to determine benefits, including psychiatric, substance abuse (drug or alcohol), psychological, assessment, diagnosis, and treatment information for the routine processing of these claims. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company. **MUST BE SIGNED IF INSURANCE IS TO PAY PALMETTO**

(Signature of Responsible Party) (Date)

Witnessed by Palmetto Counseling Office Staff (Date)

Authorization to Release Protected Health Information

I, _____ (client), whose Date of Birth is _____, authorize **Palmetto Counseling & Consulting Services, LLC** (“Palmetto”) to disclose to and/or obtain from: (i) the insurance carrier(s) for which I have provided coverage information to Palmetto, and (ii)

_____ the following protected health information (as that term is used in HIPAA) [Insert Name of Primary Care Physician, Psychiatrist, Practice, or Organization]:

Description of Information to be Disclosed (Patient/Client to initial each item to be disclosed or Initial for ALL checked)

- | | |
|--|---|
| <input type="checkbox"/> Assessment ✓
<input type="checkbox"/> Diagnosis ✓
<input type="checkbox"/> Psychosocial Evaluation ✓
<input type="checkbox"/> Psychiatric Evaluation ✓
<input type="checkbox"/> Treatment Plan or Summary ✓
<input type="checkbox"/> Current Treatment Update ✓
<input type="checkbox"/> Medication Management Information ✓
<input type="checkbox"/> Presence/Participation in Treatment ✓
<input type="checkbox"/> Nursing/Medical Information ✓
<input type="checkbox"/> Toxicological Reports/Drug Screens ✓
<input type="checkbox"/> Description of Care and Services Provided, Fees, and Charges Owed, and such Other Information as is necessary to submit a claim to my insurer(s) and be paid therefor ✓ | <input type="checkbox"/> Educational Information ✓
<input type="checkbox"/> Discharge/Transfer Summary ✓
<input type="checkbox"/> Continuing Care Plan ✓
<input type="checkbox"/> Progress in Treatment ✓
<input type="checkbox"/> Demographic Information ✓
<input type="checkbox"/> Verbal Communication ✓ |
|--|---|

_____ **Client initials to indicate agreement for All information checked** ✓

Purpose: IT IS NOT THE PURPOSE OF THIS AUTHORIZATION TO AUTHORIZE THE RELEASE OF PSYCHOTHERAPY NOTES, AS DEFINED BY HIPAA. IF I WISH OR HAVE A NEED TO AUTHORIZE THE RELEASE OF PSYCHOTHERAPY NOTES, I WILL EXECUTE A SEPARATE AUTHORIZATION AUTHORIZING THE SAME. The purpose of this disclosure of information is for treatment, payment, and health care operations, as those terms are defined in the HIPAA Privacy Rule, and to improve assessment and treatment planning, share information relevant to treatment, and, when appropriate, to coordinate treatment services. If for another purpose, please specify: N/A

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **Palmetto Counseling at 454 S. Anderson Rd, BTC Ste #115, Rock Hill, SC 29730**. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this consent expires on the following date: (i) 180 days following last treatment, or (ii) as otherwise indicated: _____

Conditions: I further understand that **Palmetto** may not condition my treatment on whether I give authorization for the requested disclosure unless allowed by 45 CFR §164.508(b)(4). However, it has been explained to me that failure to sign this authorization may have the following consequences: N/A

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. However, you recognize the potential that other types of information, where allowed by law, may be re-disclosed by the persons to whom a disclosure is made under this authorization, and that such re-disclosures may not be subject to the HIPAA Privacy Rule.

I will be given a copy of this authorization for my records, and acknowledge receiving a copy.

Signature of Patient/Client **Date**

Signature of Parent, Guardian or Personal Representative **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.). _____ **Check here if patient/client refuses to sign authorization**

Signature of Staff Witness **Date**

PALMETTO COUNSELING & CONSULTING SERVICES, LLC

**Notice of Privacy Practices and Clients Rights
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____

DOB: _____

SSN: _____

Privacy Practices

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Palmetto Counseling & Consulting Service’s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Palmetto Counseling’s Privacy Officer.

Clients Rights

I, the undersigned have been given an opportunity to read a copy of Palmetto Counseling’s Counseling Clients Rights, understand it, and agree with the stated terms. I will comply with all points contained in this document. It is understood that the clinical relationship may discontinue whenever these terms are not fulfilled by either me or the provider.

Signature of Patient/Client *Date*

*Signature or Parent, Guardian or Personal Representative ** *Date*

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member *Date*

Directions to Palmetto Counseling & Consulting Services, LLC

From Columbia, SC

Take 77 North

Take the SC-122 / DAVE LYLE BLVD exit, EXIT 79, toward DOWNTOWN

Take the SC-122 / DAVE LYLE BLVD ramp toward ROCK HILL

Turn LEFT onto DAVE LYLE BLVD / SC-122 W

Take the SC-121 / US-21-BYPASS ramp toward FORT MILL / CHESTER

Turn LEFT onto ANDERSON RD S / US-21-BYPASS / SC-121 / SC-72-BYPASS

454 Anderson Road South is on the RIGHT

From Charlotte, NC

Take 77 South

Take the SC-122 / DAVE LYLE BLVD exit, EXIT 79, toward DOWNTOWN

Merge onto DAVE LYLE BLVD / SC-122 W toward ROCK HILL / DAVE LYLE BLVD

Take the SC-121 / US-21-BYPASS ramp toward FORT MILL / CHESTER

Turn LEFT onto ANDERSON RD S / US-21-BYPASS / SC-121 / SC-72-BYPASS

454 Anderson Road South is on the RIGHT

Palmetto Counseling & Consulting Services, LLC

454 S. Anderson Road **(directly across from York Technical College) right beside ArrowPointe Federal Credit Union.**

BTC Suite #115 [1st floor of the Business Technology Center] Rock Hill, SC 29730-3392

Phone (803) 329-9639