North Grove
Counseling Associates

Kelly Bozard, LPC

Client Intake Record Form

Date: _____

Client Name(s): _____

Parent/ Guardian Name:_____
(if under 17 years of age)

Client Address:_____
Street City State Zip

Primary Phone: _____cell / work / home (Okay to leave msg?) ___Yes ___No

Alternate Phone: _____cell / work / home (Okay to leave msg?) ___Yes ___No

Email Address: _____

Emergency Contact Information:

Contact Name:_____ Relationship: _____

Emergency Phone:_____

Client Information:

Sex: M F Couple

Age:_____ Birth Date: _____ School grade (if applicable):_____

Name of School (if currently or recently enrolled):_____

Previous Counseling: Y N

If yes, When:_____ Where:_____

Presenting Problem:_____

How did you hear about us? _____

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.

Phone Number: Home:_____

(list any OK to call) Cell:_____

Work:_____

Email Address 1:_____

Email Address 2:_____

Do you check this email account regularly? Y N

Date:_____

Signature:_____

Signature:_____
(Partner - if coming as a couple)

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 North Grove Counseling Associates, 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:_____

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)

Kelly Bozard, LPC
North Grove Counseling Associates
240 North Grove Medical Park Drive
Spartanburg, SC 29303

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

I am licensed by the state of South Carolina as a Licensed Professional Counselor (LPC). My master's degree was received from Liberty University in December 2012. Before receiving my degree, I completed a one-year internship with the Spartanburg Area Mental Health Center and a six-month internship with Safe Homes Rape Crisis Coalition.

Confidentiality:

All information shared in therapy sessions will be handled confidentially unless written consent is signed. EXCEPTIONS: If I determine that you are a danger to yourself and/or to others or if there is reason to suspect child or elder abuse/neglect, if I am ordered by a court to disclose information, or if I consult with another mental health professional about your case. If a family or criminal courts of law judge subpoenas your psychotherapy chart, it must be released to them. I choose to engage in optional supervision with several professional and peer supervisors. This supervision is confidential and these individuals are therapists who are held to the same confidentiality obligations as myself; however, I try to divulge as little of your personal identifying information as possible.

Appointments/Cancellations:

You can contact me at kelly@northgrovecounseling.com or 864-699-9213 to schedule, reschedule or cancel an appointment. I am often unavailable to answer the phone, but I try to return all calls received during the work week within 36 hours. **Email is preferred when rescheduling an appointment and I do not text with clients.**

In the event that you will not be able to keep a scheduled appointment, you must notify me 36 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 36 hours' notice will be charged a late cancellation fee of $60, and clients who miss an appointment with no notice at all will be charged a $75 missed appointment fee.**

Fees:

Initial Evaluation Session (60 Minutes):	$150
Subsequent Sessions (50 Minutes):	$125
Phone or Online Sessions (50 Minutes):	$125
Late Cancellation (Less than 36 hours):	$60
Missed Appointment (No show):	$75

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 $125.

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 pre-approval 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.

If counseling is successful, clients should feel that they are able to face life's challenges without my support or intervention. Counseling sometimes allows unexpected personal issues to surface in one's life. Change in your style of relation will impact significant others within your sphere of relationships. While some clients may need only a few counseling sessions to come to a resolution of these issues, others may require months or even years in a counseling 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, 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 South Carolina Board of Examiners for Licensed Professional Counselors, Associate Counselors, and Marital and Family Therapists. A copy of this code is available upon request to the SC Department of Labor, Licensing and Regulation, 110 Centerview Dr., PO Box 11329 Columbia, SC 29211 or by phone at 803-896-4470.

In the event that you are dissatisfied with my services for any reason, please let me know.

If you have any questions regarding the counseling relationship, please ask.

Kelly Bozard, LPC

I have read and understand the information listed above. I give my consent for treatment. Please sign and date this form.

_____ Date _____

Printed Name(s)

_____

Signature

_____

Signature