North Grove
Counseling Associates

Kristin Faulkner, LISW-CP

Client Intake Record Form

Date: _____

Client's Full Name(s): _____

Parent/ Guardian Name: _____

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

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 at the below listed phone number 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: _____

Do you check this email account regularly? Y N

Date: _____

Signature:_____

Parent / Guardian Consent for Services

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 also understand that to withdraw my consent I must notify this office in writing.

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 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: _____

Kristin Faulkner, LISW-CP
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 received my Master of Social Work degree from the University of South Carolina in May 2003. I was a Licensed Master Social Worker from 2003 to 2011. In 2011 I was licensed by the state of South Carolina as a Licensed Independent Social Worker in Clinical Practice, which is the license I currently hold.

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 court of law judge subpoenas your psychotherapy chart, it must be released to them.

Fees:
Initial Evaluation Session (60 Minutes): $125
Subsequent Sessions Fee (50 Minutes): $100
Phone Sessions (50 minutes): $100
Compilation of Records: $100
Coordination of care with other providers/ attorneys: $100 per hour

Telephone Consultations are no charge for the first 10 minutes but $10 for every 10 minute segment thereafter.

Preparation of requested documents or letters and notes are subject to additional fees.

Insurance:
I do not accept any type of insurance. I bill the Adoption Medical Subsidy directly using DSS Form 30129 for services provided to children who have been adopted through SCDSS. I accept cash and personal checks only. All fees must be paid at the time of service.

Appointments/Cancellations:
You can contact me at kristin@northgrovecounseling.com or 864-415-9152. I am often unavailable to answer the phone, but I will return calls as soon as possible. E-mail is preferred when rescheduling an appointment.

In the event that you will not be able to keep a scheduled appointment, you must notify me 24 hours in advance. **If I do not receive 24-hour notice for cancellation, you will be charged a $60 missed appointment fee.**

Payment of Accounts:

Payment is expected at the time of service. Cash and checks are preferred. All returned checks will be turned over to the Solicitor's Worthless Check Unit.

It is impossible to guarantee any specific results regarding your counseling/ therapy 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 Social Work Examiners. A copy of this code is available upon request to the SC Department of Labor, Licensing and Regulation located at 110 Centerview Dr., Columbia, SC 29210. Their mailing address is: PO Box 11329 Columbia, SC 29211 and their phone numbers are: 803.896.4300 or 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/ therapeutic relationship, please ask.

Kristin Faulkner, LISW-CP

I have read and understand the information listed above. I give my consent for treatment.

Please sign and date this form.

_____ _____

Printed Name(s) Date

_____

Signature(s)