North Grove
Counseling Associates

Mitch Dawes, LPCA

Client Intake Record Form

Client Name(s):_____ Date:_____

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)

Mitchel Dawes, LPCA
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 ensure your understanding of our professional relationship.

Qualifications:

I am currently licensed by the state of South Carolina as a Licensed Professional Counselor Associate (LPCA). I obtained my master's degree in clinical mental health counseling from Gordon Conwell Theological Seminary in May 2021. Gordon Conwell is a CACREEP accredited program. I have counseled diverse populations and various mental health issues working at the University of South Carolina Upstate counseling services and the Carolina Center for Behavioral Health for my clinical internships.

Confidentiality:

Shared personal information is strictly confidential and will not be revealed unless you, or a parent in the case of a child under 18 years old, give specific written authorization to release information. Additional exceptions include (but are not limited to): If I determine that you are a danger to yourself and/or to others, 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 am required to be under supervision by a qualified supervisor and may also choose to engage in optional supervision with other professionals and/or peers. This supervision is confidential, and these individuals are therapists who are held to the same confidentiality obligations as myself. Additionally, at all times I try to divulge as little of your personal identifying information as possible.

Appointments/Cancellations:

You can contact me at (864) 310-6881 or email me at mitch@northgrovecounseling.com to schedule, reschedule, or cancel an appointment. If you will not be able to keep a scheduled appointment, I request a 36-hour notice. **If you fail to give proper notice you will be charged a late cancellation fee of $45 and if you miss an appointment with no notice, you will be charged a $60 missed appointment fee**. This charge will be waived only one time. Repeated rescheduling (3 consecutive) will result in termination of counseling services. I prefer email as the primary means to contact me or reschedule appointments and do not text with clients.

Fees:

Initial Evaluation Session (60 minutes):	$125
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 30 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.

Insurance:

I do not take or file insurance for my clients. All fees must be paid at the time of service. I can provide a diagnosis, billing code, and receipt for services if you plan to submit a claim to your insurance. Clients are encouraged to seek preapproval with their insurance before starting therapy in order to ensure the highest rate of reimbursement.

Payment:

Your payment is due at the time of the service. Cash, checks, and credit cards accepted. 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 Examiners for Licensed Professional Counselors, Associate Counselors, and Marital and Family Therapists. A copy of the code is available upon request by the SC Department of Labor, Licensing and Regulation, 110 Centerview Dr., PO Box 11329 Columbia, SC 29211, or by phone at 803.896.4470.

If 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.

Mitchel Dawes, LPCA

Acceptance of Terms:

I have read and understood the information listed above. I agree to abide by these terms and give my consent for treatment.

Please sign and date this form.

_____ Date _____

Printed Name(s)

_____

Signature(s)