Christian Life Counseling of SWVA, LLC
602 Radford Street
Christiansburg, VA 24073
540-382-1751 (phone)
540-382-1740 (fax)
www.christiancounselingswva.com

Thank you for choosing us to serve you. Your initial appointment will take approximately an hour. There is a lot to accomplish during this appointment. We realize that seeking counseling is a big step towards making positive changes in your life. If you have not been in counseling before, you might not know what to expect and have some anxiety. It is our intent to make you feel comfortable and safe to share whatever issues you are experiencing. There are some business and professional aspects that we complete with you before counseling can begin. It is important for you to complete this packet prior to your appointment for a thorough assessment and productive session. Your counselor will review the packet with you and answer any questions or concerns you may have.

Our practice consists of the following counselors:

- Lisa F. Pugh, LPC
- Tiffany McCann-Vaught, LPC
- Kimberly D. Price, LPC
- Stephanie Whited, LCSW

We are a group of independent counselors that have joined together to meet a need in the area for faith-based counseling. The name of our practice was chosen to make us easy to find for people wanting Christian counseling. We all have earned graduate degrees from accredited universities. All of us are licensed to practice counseling in the Virginia Department of Health Professions. We have a desire to help others heal and grow using their faith using a Biblical World view. However, not all our clients desire Christian counseling. We are trained and willing to provide secular based counseling. Our goal for all our clients is to provide a safe, caring and nonjudgmental environment. Your counselor will only practice within her training and experience. You are encouraged to view your counselor's bio on our website and choose a counselor that you feel can best help you. Your counselor may refer you to someone else if she cannot meet your needs.

Office hours are by appointment only. Some counselors have only part-time limited hours. Some counselors are full time.

Once you have talked with your counselor, you will be given a direct cell phone number to reach her. You will no longer call the office number. You will be able to reach her directly. You will also have her email address. Please feel free to leave a message if it is not a crisis. Your counselor will return your call as soon as possible. However please note, we do not provide emergency or crisis services. Do not leave a message if you are having a psychiatric emergency. **In the event of a psychiatric emergency, please call ACCESS at 540-961-8300, call 911 or go to the Emergency Room**.

Your counselor is _____. Her cell number is _____. (You can save in your contacts). Her email is_____ (Your counselor will complete this section and return it to you for future reference.)

Adult Client Intake Information

Name: _____

Age: _____ Date of Birth: _____ / _____ / _____

Person completing this form _____if not client what is your relation to client?_____

Phone Number: _____(the best number to reach you at)

May we leave voicemails? Yes No If cell phone, may we text? Yes No

Physical Address:

_____

_____

Mailing Address (if different from above):

_____

_____

May we send mail to your home? Yes No (If will are billing your insurance, we cannot prevent insurance from sending EOB (Explanation of Benefit) forms to you).

If we can email you, please list your email address:_____
By giving us your email, you agree and understand that there is a risk that the transmission could be disrupted or interrupted by unauthorized persons.

Are you (Circle One): Single Married Divorced Engaged In a Relationship Widowed
Other: _____

*Do you have a guardian (court appointed)? Yes No If yes, name: _____

*If under the age of 17, what is the custody agreement if parents are not married?_____

***Copy of court document is required**

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Referred by: _____How did you find out about us?_____

Presenting Problem (Why are you seeking Counseling?):

_____
_____
_____
_____
_____

How long have you been dealing with this challenge? _____

What would you like counseling to do for you? What you're your goals for counseling? _____

_____

_____

<u>CIRCLE</u> or <u>CHECK</u> any of the following that apply to you now or within the past month

Depression	Increased alcohol use	Nervous/Anxious
Crying spells	Increased drug usage	Panic attacks
Hopelessness	Blackouts/memory loss	Can't concentrate
Relationship breakup	Withdrawal symptoms	Confusion
Loneliness	Financial worries	Mood swings
Emptiness	Loss of control in:	Racing thoughts
Loss of appetite	alcohol/drug use	Fear of dying
Sleep disturbance	overeating/bingeing	Job stress
Nightmares	purging	Decreased activity
Thoughts of harming self	yelling/breaking	Not seeing friends
Thoughts of harming others	hitting people	Feel controlled
Suicide attempts/injuries	endangering self	Feel talked about
Hearing voices	endangering others	Guilt/shame
Seeing things others don't	spending	Sexual problems
Unusual thoughts	gambling	School problems

Please explain circled or checked items:

_____

_____

_____

Safety Issues & Risk

Have you ever tried to kill yourself? Yes No If yes, please explain:

_____

_____

Have you ever thought about suicide? Yes No If yes, please explain:

_____

_____

Have you ever tried to hurt someone else, or thought about it? Yes No If yes, please explain:

_____

_____

Have you ever done anything to hurt yourself on purpose? Yes No If yes, please explain:

_____

_____

Trauma

Abuse: Yes No Decline to answer
Sexual Abuse: Yes No Decline to answer
Neglect: Yes No Decline to answer
Domestic Violence: Yes No Decline to answer
Other Trauma: Yes No Decline to answer

If you would like, can you say what happened?

_____

_____

_____

_____

_____

_____

ETHNIC Background: _____

Any ethnic problems/concerns? _____

RELIGIOUS/SPIRITUAL Background:

_____

Current religious/spiritual activity: _____

Do you have any spiritual concerns now? _____

PREVIOUS MENTAL HEALTH TREATMENT:

Were you ever been **hospitalized** for psychiatric and/or substance abuse reasons (depression, hearing voices or other mental or emotional problems, etc.)? _____

If yes, please answer the following questions: how many times? _____ Any involuntary?_____

Where/when/why? _____

_____

Year of last admission: _____ Where/when/why: _____

_____

Have you ever been to a hospital emergency department for mental health or substance abuse reasons?_____**If yes,** please answer the following questions: how many times? _____ _____

Where/when/why? _____

_____

Have you received any **outpatient counseling**? _____If yes, Where, when, why, & was it helpful:

_____

_____

Have you ever been involved in any **support groups** (Grief Share, Divorce Care, Recovery, AA, NA, ACOA, Alanon, etc.)? ____**If yes**, when, type of group(s) and was it helpful? _____

_____

Has anyone in your FAMILY ever been treated or diagnosed with mental or emotional problems? hospitalized for depression or any other mental or emotional problems?_____

If yes, explain who, when and reason: _____

_____

<u>Substance Use</u>

Do you drink alcohol: Yes No Former User

What type? _____

How often? _____

Do you use tobacco products: Yes No Former User

What type? _____

How often? _____

Do you use drugs (prescription pills – not prescribed, Opiates, Methamphetamines, Marijuana, Hallucinogens, Other types): Yes No Former User

What type(s) ? _____

How often? _____

Additional Comments regarding substance use:

_____
_____
_____
_____

Physical Health

CHECK THE APPROPRIATE BOX FOR EACH ITEM THAT APPLIED TO YOU IN THE PAST OR NOW, AND THEN EXPLAIN BELOW:

	none	self	family history		none	self	Family history
Allergies				Heart Problems			
Asthma				Hepatitis			
Diabetes				Head Injuries			
Cancer				Alcohol/drugs			
Seizures				Speech problems			
Hearing problems				Vision problems			
Stomach problems				Fall risk			
colitis				Thyroid problems			
Chronic fatigue				Vitamin defiencies			
High blood pressure				Low blood pressure			
Low blood sugar				HIV / AIDS			
Circulation problems				TB			
High Cholesterol				Sever head aches/migraines			
Irritable bowel				Weight loss			n/a
Liver Disease				Weight gain			n/a
Chronic pain				other			
Dental problems				other			

Feel free to explain any medical problem (s)_____

_____

_____

Are you on **Medications**? If so, what medications, dosage and purpose?

_____

_____

_____

Date of last physical: _____ Any problems? _____

Do you eat a regular balanced diet? _____ Do you skip meals? _____

Any poor eating/junk-food habits? _____

Do you exercise regularly? _____ How often? _____

Women Only

Are you currently pregnant? Yes No

How many pregnancies have you had _____

Live births _____

Miscarriages _____

Abortions _____

Premenstrual syndrome? _____Menopause? _____ Hormone therapy? _____

MARITAL STATUS:

Unmarried _____

Live together _____ How many years? _____

Married _____ How many years? _____

Separated _____ How many years? _____

Divorced _____ How many years? _____

Widowed _____ How many years? _____

Number of times married: _____

Who lives in your home?

_____

Do you have children and/or stepchildren? Yes No **If yes**, please list ages and sex of each_____

You were raised by: _____

Number of brothers/sisters: _____# living: _____ # older than you: _____

younger than you: _____additional information_____

Family members you are close to : _____

Developmental History

Do you know if your mother had any complications while she was pregnant? Yes No Unknown

If yes, what: _____

Were there complications when you were born? Yes No Unknown

If yes, what: _____

EDUCATION: Last grade completed: ____ Degree: _____ In school now? _____

Special training or skills: _____

Hope/plan to go to school? _____

Have a learning difficulty? _____

EMPLOYMENT: Employed____retired_____unemployed____disabled_____What do you do or did for a living? _____

Current Employer if applicable_____ Years on job: _____

Legal History

Current or Past Criminal Charges

_____

_____

_____

_____

Are you currently on Probation or Parole? Yes No

Are there any active restraining orders associated with you? Yes No

Are you court-ordered to attend counseling? Yes No

INTERESTS/ACTIVITIES (Circle or check):

Television	Be with friends	Shopping	Fix/repair things
Movies/videos/DVDs	Be with family	School	Sew/knit/crochet
Music	Be alone	camping	Build/decorate
Play instrument	Cooking/eating	Exercise	Gardening
Singing	Play sports	Photography	Drawing
Dancing	Volunteer work	watch sports	Video games
Reading	Travel/sight-see	Hiking	Care for elderly
Writing	Prayer/Church	Gambling	Child-care
Drawing	Pets		

Other interests/activities:

_____

Have you recently lost interest in activities you normally enjoy?

_____

Do you feel you spend enough time on your interests or non-work activity?

_____

MILITARY SERVICE: Type: _____ When: _____

Honorable discharge? _____ If not, why? _____

Describe any combat experience:_____

Are you troubled now by your experience in the military? _____

Is there anything you would like to share that has not been asked or mentioned in this questionnaire or further explain?

By signing this form, I affirm, that to my knowledge, the information provided is correct. I understand that the more information I provide, the better my counselor can support me.

Client Signature: _____ Date: _____

Counselor signature_____ Date:_____

Notification of Privacy Practices

This notice describes how private personal medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your Privacy is important to us: This notice describes how your health information may be used and disclosed while being served by Christian Life Counseling of SWVA (independent providers: Lisa F. Pugh, LPC and Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC & Stephanie Whited, LCSW). We are required to abide by the terms of this notice.

Documentation: Each time you receive services from us, we make a record of the contact. Types of information kept in your record may include written assessments, treatment plans, progress notes, diagnoses, treatment records, transition and/or discharge planning.

Billing and payment use of your health information: To receive payment of services, your health information may be sent to companies or groups responsible for payment coverage. A bill from (Lisa F. Pugh, LPC or Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC or Stephanie Whited, LCSW) is sent to the responsible party you have identified.

Your Privacy Rights: are defined under 45 CFR Parts 160 and 164, HIPPA, The American Reinvestment and Recovery Act of 2009, and The Commonwealth of Virginia's Code 35-115-80 and 35-115-90, Human Rights. The HIPAA Privacy Rule establishes rights for recipients of health care and provides clients with authority over their health care information.

The HIPAA Privacy Rule Gives You the Right to:

- **Access to review and gain copies of your health records and make corrections**: You have the right to have access to your medical record in order to inspect, challenge, copy, amend, or correct it. The right is not absolute. In certain situations, access may be denied if a physician or psychologist believes that reviewing your records would result in harm to self or others. Make this request by contacting your counselor. If denied access, you will receive a timely, written notice of the decision and reason. A copy of this written notice becomes a part of your record.
- **Receive an accounting of disclosures**: You have the right to receive an accounting of all disclosures of your protected health information that were not part of providing treatment, receiving payment, or other health care operations, or already authorized by you.
- **Request a Restriction of Specific staff access to Your records**: You have the right to request a restriction of use with use and disclosure of your protected health information. We seriously consider all restriction requests and you will be informed whether we are able to use the restriction and still offer effective services, receive payment, and maintain health care operations. Legally we are not required to agree to a restriction if the restriction keeps us from providing or billing for services.
- **Receive Private & Confidential Communication**: You have the right to receive confidential communications about your protected health information.
- **Change How we contact you**: You have the right to request an alternative mode of communication or contact for billing purposes and for service related contacts such as calls to remind you about an appointment.

Use & Disclosure of Information:

- "**Use" of Your Health Information**: Upon signing the Notification of Privacy, Human Rights and Informed Consent for Treatment forms, you are allowing us to use and disclose necessary health information about you within the private practice and with business associates in order to provide services, collect payments for services provided, and conduct other day to day business practices.
- **Minimum Necessary Rule**: We use the minimum amount of health care information necessary when responding to appropriate needs for information.
- **"Disclosure" of your health information**: We are required to get your authorization to use or disclose your protected health information when it is shared outside of the private practice. Communication and coordination of services with other providers or agencies may be necessary during the course of providing care. We use a written Authorization for Release of Protected Health Information form that specifically states what information will be given to whom, for what purpose(s), and is signed by you or

your legal representative. You have the ability to revoke a signed authorization but it would not apply to any sharing of information that already occurred under that authorization. You have a right to obtain a copy of any authorizations you sign.

- **When We cannot Confirm or Deny**: If we are approached with a request for your health care information that we believe to be unauthorized or for which we have no current or active authorization to disclose information signed by you, then we cannot confirm or deny either that you are a client or that we possess health care information about you. If you have needs that require me to communicate with others for any purpose, such as transportation or appointment dates and times, please notify me so that we can gain an appropriate authorization for the specific types of communication necessary.

Other Ways We May use Your Health Information:

- **Consultation**: In order to effectively provide services, we may consult within the private practice. During consultation health information about you may be shared. In day-to-day business practices, trained staff may handle and use your health information when filing documents, storing and securing files and folders, process insurance authorizations perform billing functions, or assure that your information is current and readily accessible to our clinical staff.
- **Quality Improvement**: As a part of our continuous quality improvement efforts to provide the most effective services, your record may be reviewed and audited by staff to assure accuracy, completeness and organizations. Your health information may also be reviewed during audits by state, federal and/or private oversight or regulatory boards.
- **Enhancing Your Healthcare**: We may provide the following support to enhance your overall health care and may contact you to provide: appointment reminders by phone call, text, email or letter informing you about treatment options or information about health-related benefits and services that may be of interest to you.
- **Specific Circumstances for Disclosure**: Although you have the right to give or not give consent to the disclosure of your health information, we are allowed by federal and state law in certain circumstances to disclose specific health information about you without your consent, authorization, or opportunity to agree or object. Communication or sharing of information may occur for the following:
- **As required by law** (example: court-ordered warrant, Virginia Health Information)
- **Public Health activities** (example: communicable diseases)
- **Judicial and Administrative proceedings** (example order from a court or administrative tribunal, or legal counsel to the agency, or Inspector General)
- **Law enforcement** purposes (example: reporting of gunshot wounds, limited information requested about suspects, fugitives, material witnesses, missing persons, criminal conduct on agency premises).
- **To avert a serious threat to health and safety** (example: in response to a statement made by client to harm self or another or substantial property damage.)
- **To protect children or incapacitated adults who are victims of abuse, neglect or exploitation** by reporting suspected abuse to the Department of Social Services - Child or Adult Protective Services.

Specialized Government Functions: We may communicate with state and federal government in certain situations and for certain purposes without your permission. These include: Military Services (ex: in response to appropriate military command to assure the proper execution of the military mission); National Security and Intelligence activities (ex: in relation to protective services to the President of the United States); State Department (ex: medical suitability for the purpose of security clearance); Correctional facilities (ex: to correctional facility about an inmate); Workers Compensation to facilitate processing and payment; Coroners and Medical Examiners for identification of a deceased person or to determine cause of death. Documentation will be included in your health record of information disclosed without authorization or those not covered under the permissions granted in the Notification of Privacy, Human Rights and Informed consent for Treatment or your Individualized Service Plan.
Breach Notification: The Health Information Technology for Economic and Clinical Health Act (HITECH), which is part of the American Recovery and Reinvestment Act of 2009 (ARRA) enacted February 17, 2009, requires that we notify you if we discover that your health care information is ever disclosed to, accessed by, or used by an unauthorized person or entity. It also applies to disclosures of protected health information, which compromises

the security and privacy of the health information. This type of unauthorized exposure to PHI is referred to as a "breach" and applies to me and my business associates. We must respond to the breach events by notifying any and all clients whose information was accessed or disclosed and notify the federal government my informing the Department of Health and Human Services. In the event of a privacy breach of your health information, you will receive formal written notification.

Use or disclosure of protected health information that is incident to an otherwise permissible use or disclosure and occurs despite reasonable safeguards and proper minimum necessary procedures would not be a violation of the Privacy Rule pursuant to 45 CFR 164.502(a)(1)(iii) and, therefore, would not qualify as a potential breach. Violations of administrative requirements, such as lack of reasonable safeguards or a lack of training, do not themselves qualify as potential breaches under this law.

Disposition and Retention of Medical Records Upon Discharge: As directed by the Code of Virginia, we have included this information to inform you of how we handle medical records of persons who are no longer receiving services from the private practice. You are welcome to contact us at: 602 Radford Street, Christiansburg, VA 24073 or 540-382-1751 if you have any questions.

The standard procedure is to retain medical records for a period of at least six (6) years past the date of discharge. At that time, if there is no indication that the discharged individual is planning to return to our agency to receive services, then the medical records for that individual may be destroyed per Virginia (18VAC85-20-26) which state that practitioners must maintain a patient record for a minimum of six (6) years following the last patient encounter with the following exceptions:

- Records of a minor child, including immunizations, must maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time foe record retention of six (6) years from the last patient encounter regardless of the age of the child
- Records that have previously been transferred to another practitioner or health care provider to the patient or his personal representative; or
- Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

As a client of Christian Life Counseling of SWVA (independent providers Lisa F. Pugh, LPC and/or Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC and/or Stephanie Whited, LCSW) you have the following rights:

- To receive services in the least restrictive environment, and to be free from any unnecessary use of seclusion, restriction, or time out. To be treated with dignity and in a professional and courteous manner; to be protected from harm including abuse, harassment, neglect and exploitation.
- To use your preferred or legal name.
- To have your protected health information treated with confidentiality and not released without written consent, except for situations required by law as noted previously. You have the right to determine what information is disclosed, to whom, and the purposes for which it will be used. You have the right to be provided an accounting of disclosures.
- To read, request amendment to, or obtain a copy of your service record, except in instances as noted in this privacy notice. You have the right to be notified of changes in the regulations regarding privacy of protected health information.
- To receive services meeting your individual needs and abilities according to law and sound therapeutic practice. To be involved in all aspects of services provided to you and given information to help you make decisions. To ask questions of your counselor about services including treatment and discharge planning and to share any concerns regarding services provided to you. To be provided with general information about services, policies, and rules in writing and in the manner format and language easily understood by me. To be provided help in learning about/applying for public services or benefits to which you may be entitled.
- To not to be included in any experimental program or research without your knowledge and written consent.

- To have opportunities to communicate in private with lawyers, judges, legislators, clergy, licensed health care practitioners, legally authorized representatives, advocates, and the Inspector General; and have access to an advocate or representative, self-help groups, and legal services.
- If you have a compliant regarding me or the services provided, you have the right to have make your compliant without negative action being taken against complaining.
- To be afforded the opportunity to have an individual of your choice notified of my general condition, location, and transfer to another facility

To make a complaint:

- You can talk with your counselor to resolve the issue
- If you feel that we have not resolved the issue. You can contact the Local Human Rights Advocate DBHDS Southwest Satellite Office, 340 Bagley Circle, Marion, VA 24354. Phone (276) 783-1219 or toll free (877) 600-7434.

You can contact the VA Board of Counseling, 9960 Mayland Dr, Richmond, VA 23233 (804) 367-4610, https://www.dhp.virginia.gov/counseling I have read or had read to me the Notification of Privacy and Human Rights agreement.

I understand that I can request a copy of this agreement. Also, I realize that I can access an unsigned copy on www.christiancounselingswva.com

_____ _____
Client Signature Date

_____ _____
Parent or Guardian signature (if applicable) Date

_____ _____
Counselor (Independent Provider) Date

Informed Consent for treatment:

I, _____ hereby agree to receive services and consent to the standard and customary procedures of evaluation and treatment as prescribed by Christian Life Counseling of SWVA (independent providers Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC, Stephanie Whited, LCSW)
[ ] myself
[ ] _____for whom I serve as the legal guardian (must provide documentation as to proof of guardianship)

I understand that my agreement and consent applies to all services I, or the person whom I am signing for may receive during care. This signed Notification of Privacy, Human Rights and Informed Consent for Treatment forms are valid for up to one year from the date of the signature, until time of voluntary discharge, or upon revocation.
In addition to my informed consent for treatment, I authorize the following:

Medical Emergency: In the event of a medical emergency, I hereby authorize Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC or Stephanie Whited, LCSW to apply basic first aid and CPR measures, to call my personal physician, and/or to call the local rescue squad if it is indicated. I further give my consent for the transport of myself, or the person for whom I am signing, if necessary to facilitate medical care. They may also contact the person/agency listed below as those to be notified in case of an emergency.

Emergency Contact:
_____Relationship_____
Phone #_____Cell #_____Work #_____

_____ _____
Client Signature Date

_____ _____
Parent or Guardian signature (if applicable) Date

_____ _____
Counselor (Independent Provider) Date

Financial Consent to Pay

- I agree to notify (independent providers Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC and/or) Stephanie Whited, LCSW of any changes in financial/insurance information. I agree to pay all non-covered charges for services provided. I shall pay these charges at the time of service unless alternative arrangements are made.
- I hereby authorize payments directly to the independent providers Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC and/or Stephanie Whited, LCSW for any third party benefits to which I am entitled. I agree to pay 100% of any co-payments or deductibles at the time of service. I further authorize the release of medical/clinical information necessary in order to process third party claims.
- I understand that by signing this consent, HIPPA regulations permit independent providers Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC and/or Stephanie Whited, LCSW to use established collection procedures, including debt-set off and/or a collection agency that operates as a business associate of independent providers Lisa F. Pugh, LPC ,Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC and/or Stephanie Whited, LCSW if I do not meet my payment responsibilities. This signed consent permits the limited disclosure of my protected health information necessary to recover payment. I understand that I will be charged for any collection fees and/or legal fees in recovery payment for services.
- I will be charged $35 for any payments returned as non-sufficient or non-payable.
- I understand that I can be charged a $50 for a no show for an appointment (Unless not allowed by insurance provider). I will give 24 hour notice if possible.
- I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records., 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically when my financial obligations to the independent providers Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC and/or Stephanie Whited, LCSW. This consent includes information placed in my records after the date indicated below.

Insurance

Do you have insurance and want your counselor to bill insurance for your services ? Yes No
If yes, please complete the following questions. <u>If the answer is no, skip to the self-pay option.</u>

Is this your counselor an approved provider? Yes No Unsure If not, your insurance may not pay or partially pay leaving you responsible for the amount not covered.

A copy of your insurance card and Driver's license/ID is required.

Primary Insurance _____

Subscriber's name: _____ Relationship to Client: _____

Subscriber's DOB: _____Subscriber's address _____Subscriber's phone _____

(If applicable) Secondary Insurance Co. Name: _____ _____

Insurance Co. address: _____

Subscriber's name: _____ Relationship to Client: _____

Subscriber's DOB: _____Subscriber's phone_____Subscriber's address _____

Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC and Stephanie Whited, LCSW are independent providers and bill separately for their services. I hereby authorize and request my insurance to pay directly to my independent provider (Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC or Stephanie Whited, LCSW) the amount due for services rendered. Release of information: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject at state and federal confidentiality requirements. I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by my independent provider (Lisa F. Pugh, LPC and Tiffany McCann-Vaught, LPC , Kimberly D. Price, LPC or Stephanie Whited, LCSW) If my provider is contracted with the insurance company, I will be responsible for all co-pay, deductible, and non-covered services as determined by the insurance plan. However, if the insurance does not cover services or does not pay within 90 days, I will be responsible for the entire amount due. We do not participate in court appearances and proceedings of civil matters (including custody, separation, divorce etc.). Insurance does not pay for phone consults, copies of records and/or written correspondence. Your independent provider may charge for these services. If there will be a charge, the independent provider will let you know the amount prior to doing the service.

Guarantor Signature: _____

Print Name: _____ Date: _____

SELF PAY (no insurance or do not bill insurance)

I wish to self-pay for my services.
In doing so, I receive an automatic significant discount.

Individual Intake (first session) $75
Individual sessions (2nd and after) $65
Couples Intake (first session) $100
Couples Sessions (2nd and after) $85

Guarantor Name: _____Date of Birth: _____

Guarantor Address: _____

Guarantor relationship to client (circle one) Mother, Father, Self, Other: _____

Phone _____

A copy of your Driver's license/ ID is required.

I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC, Kimberly D. Price, LPC and/or Stephanie Whited, LCSW.

I will be responsible for the entire amount due by cash, check, credit or debit card at the time of service.

I will be charged $35 for any payments returned as non-sufficient or non-payable.

I understand that I can be charged a $50 for a no show for an appointment. I will give 24 hour notice if possible.

Guarantor Signature: _____

Print Name: _____ Date: _____