Name: _____ DOB: _____ Date: _____

Provider: Erin Bland, MSW, LCSW

Receipt of Notices and Request for Services

_____ I have read the attached Professional Disclosure statement for Erin Bland, MSW, LCSW an employee of LifeCare Counseling and Coaching.

_____ I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____ I hereby request professional services from this professional. I understand the first one or two visits are for evaluation purposes and are not a guarantee of further treatment. If ongoing treatment at this office is indicated and mutually agreeable then a treatment plan will be agreed upon at the end of the evaluation.

_____ (Optional) I am willing to allow an intern to sit in on our sessions in that I understand that a mission of LifeCare is to train and license future counselors.

Financial Responsibility

_____ I hereby unconditionally guarantee payment to LifeCare Counseling and Coaching for all costs, charges and expenses incurred by said client at this office, unless separate arrangements are agreed upon in writing. I agree to have my credit card number on file for payment and authorize that card to be used to cover any unpaid balances.

_____ I also agree to pay a service charge of $40.00 for any checks that are returned unpaid. I understand if the client balance for services provided is not paid within thirty days of billing date, the amount due will be deemed delinquent.

Insurance/Third Party Payment

_____ I understand it is my responsibility to inform the office of any changes in my insurance, prior to the effective date of the change and accept financial responsibility for any office charges that were incurred prior to this date.

____ If I have third-party reimbursement, I understand it is only for the services they have agreed to cover. I understand that any additional services I desire are being provided outside this insurance arrangement, and I accept full financial responsibility for these services.

____ I certify the following information to be accurate: (Check **one** below)

___ 1) **No Insurance.** I have no insurance, or request that no insurance claims be filed by the office. I will accept full financial responsibility for any services the office provides.

___ 2) **Using Insurance, but Out of Network.** I have insurance/third party coverage with:

_____. I understand there is not a contract between this payer and the office for this provider's services. I accept financial responsibility for my bill regardless of whatever action my insurer takes. I request that claims be files with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office.

___ 3)**Contract with Insurance/In-network.** I have insurance/third party coverage with:

_____. I understand there is a contract between this payer and the office for this provider's services. I accept responsibility for any deductibles and co-payments specified by this contract. I request that claims be filed with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office. I accept financial responsibility for any services I desire that are not covered by my insurer.

_____ _____
Client Date

_____ _____
Legally Responsible Person Date

_____ _____
Provider Date

1601 Jones Franklin Road, Suite 104, Raleigh, NC 27606 TEL (919) 851-1527 Fax (919) 851-3555

Erin Bland, MSW, LCSW
Professional Disclosure Statement

Credentials

Bachelors of Arts Degree in Social Work, Asbury College
Masters of Social Work, University of Kentucky
Licensed Clinical Social Worker, 2011, NC License #C007279

Professional Experience and Services

Completed a program at Focus on the Family Leadership Institute which included courses on marriage and family, parenting, apologetics and the church's role in society. She has extensive experience in the field of adoption, working with birthparents, adoptive families and children, couples experiencing infertility/miscarriages and post-abortive women and men.

Fee Schedule

Psychotherapy 55-60 min	$120 (only this may be covered by insurance)
No-Show	Full Fee
Late-Cancellation	One-half of full fee
Telephone Consultation	Based on time required
Reports and Letters	Based on time required
Photocopying	Based on number of pages
Court Preparation/Appearances	$200 an hour

Payment, Insurance Reimbursement, and Problem Resolution

It is our policy to receive payment for services at the time they are provided. Cash, personal checks, credit and debit cards are acceptable forms of payment. As a convenience to you, we will file your claim with your insurance company. If you are unable to keep an appointment, please call to cancel the business day prior 24 hours before your appointment. Less than that will be considered a late- cancellation. No call or not coming to your appointment will result in a No-show fee. No-show and late-cancellation fees are listed above.

In surveying other practices in the area, our fee of $120 per session is in line or below the prevailing rates for professional licensed psychotherapy services. At LifeCare, we are committed to provide you with excellence in Christian counseling. Our counselors are well-trained, board certified, and experienced in dealing with a wide variety of needs. We sincerely appreciate the opportunity to help you with your current concerns.

We are in-network providers with Blue Cross Blue Shield of North Carolina, except for Blue Local plans. Some of our providers are also in-network with United Healthcare and Cigna, but not all. Please check with your therapist regarding whether they are in-network for your plan. Please be aware that some insurance companies contract mental health benefits out to a different insurer who may be out-of-network. Your insurance company can confirm your benefits.

We are out-of-network providers for all other insurance plans. As a convenience to you we will make every effort to file a claim on your behalf. If we are not able to file the claim we will provide you with the appropriate forms so you may file the claim yourself. We ask for the full fee at the time of service, then file the claim and assign payment of any benefits to come directly to you personally. We are not accepted providers for Medicaid or Medicare.

If you are dissatisfied with any aspect of the services provided by me, please inform me so that we can address your concerns. If we cannot come to a satisfactory resolution, you may speak further with me or with Maria Lyons, Office Manager. If after doing so you are still dissatisfied, you may contact the NCSWCLB at PO Box 1043, Asheboro, NC 27204.

COURT PREPARATION/APPEARANCES:

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement and clinical schedule readjustments, I charge $200 per hour for preparation and attendance at any legal proceeding. (You will be held responsible for payment for the professional time required even if I am compelled to testify by another party. An agreed upon amount will be rendered *in advance* and held in escrow. Any left-over amounts will be returned to you upon resolution of the legal matter.)

CONFIDENTIALITY

The confidentiality of your personal health information is very important to us. We may use and disclose your personal information without authorization for the following purposes: abuse, neglect, domestic violence, or court order.
As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse to self or others, neglect, domestic violence, or court order. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Minors and Disabled Adults

When working with clients who are minors or adults who are legally incapable of giving consent, I will obtain consent from a parent or legally authorized representative. For children who are clients, it will be determined the extent that he or she has an understanding of privacy based on chronological age and cognitive ability. If the child has no concept of privacy, then I am free to share information with parents without informing the child first.

Pre-adolescents and adolescents will be seen on an" informed forced consent" in that information will be handled as confidential, but it is up to the therapist to decide what information is pertinent to share with the parents. Sometimes it is in the best interest of the minor client not to disclose all information to the parents that the child shares with the therapist so as to strengthen the therapeutic alliance and work through issues with the minor. Parents of the minor will be given updates of progress of goals and treatment plans on a scheduled basis. When it is determined that information should be shared for therapeutic reasons or as part of family counseling, the client will be informed and consulted and/or included in sharing the information to the parents or guardians. This of course, is superseded by any of the exceptions of confidentiality (danger to self or others, abuse, or court order) as stated in the above paragraph.

When working with two or more persons who have a relationship such as in a group, family or marriage, I will clarify at the outset who is the primary client as an individual or family unit. I will not share confidences by one family or group member to others outside the family without permission or prior agreement of all members except described in legal exceptions of threat of serious harm to self or others as described above in paragraph one.

Marriage Counseling

With couples specifically, my counseling work will focus on both your relationship and each of you as individuals. In order to maintain fidelity to both of you and your relationship, it is important that we agree on these policies:

1) I may share any information conveyed to me by either of you with the other member of the couple. Please do not expect me to keep secrets where doing so jeopardizes the therapeutic work or my relationship with either of you or your relationship. Please be aware that information you choose to share with me that is particularly pertinent to both of you may come out in therapy. This includes all verbal, written and phone conversations and messages.

2) If I meet with one or both of you in an individual session, we will likely share the contents of that meeting with the partner in a couples' session in the near future.

3) The continued participation by each person is voluntary. Either participant may suspend or terminate the therapy at his or her individual request. At that time, client confidentiality remains solely with the client who is continuing therapy.

At times, I also may receive peer supervision from other counselors at LifeCare Counseling and Coaching without revealing any of your identity, so as to help me serve you better in counseling.

Please see "Notice of Privacy Practices" for more detailed information about confidentiality of service and records.

_____ _____

Client Date

_____ _____

Counselor Date

LifeCare Counseling
Adult Self-Report Form

Therapist: Erin Bland, LCSW

I look forward to meeting with you in the near future. In order to achieve optimum results through the counseling process, it is important to gather a significant amount of information to provide me with a picture of who you are. If there are any questions you do not feel comfortable answering or would rather discuss in person, please feel free to leave it blank. If you have any questions, please let me know.

Name: _____ Date of Birth:_____

Primary Concern

Please describe the main difficulties that have brought you to counseling. How would you prioritize the issues that you would like to work on?

If you have symptoms, how would you describe them and when did they first appear?

Physical Health History **(From whom or where do you get your current medical care?)**

Clinic name/Physician:

Phone:

Date of last appointment:

Current physical or previous medical concerns (injuries, illness, allergies, etc.):

Please list all current psychiatric and non-psychiatric medications and daily dosages:

Medication	Dosage	Reason for taking	Prescriber

Mental Health History

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

Previous Diagnosis?

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate the most recent:

When:

From Whom:

For What:

Results: What was the outcome of this treatment? Was it helpful to you (why or why not)?

Have you attempted to commit suicide or homicide in the past? Yes No

Is there a history of suicide in your nuclear or extended family? Yes No

Any current thoughts of hurting yourself? Yes No

Any current thoughts of hurting someone else? Yes No

Have you ever inflicted burns or wounds to yourself? Yes No

Do you have any current safety concerns? Yes No

Please ensure that you listed any psychiatric medications in the previous medical section.

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume alcohol? _____

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Any current use or history of problematic use of prescribed or non-prescribed drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

Have you experienced a recent increase in the use of alcohol or other substances? Yes No

Do you view your current usage as a problem? Yes No

If yes, when did it become problematic? _____

Substance	Age of 1st Use	Last Use	Frequency	Current Use

If prior substance abuse, what is the longest period of sobriety? Triggers for relapse?

Community Supports used, if any? (i.e. AA)

Legal History

Do you have any past or current legal issues? If yes, please describe.

Family of Origin

Do any of your family members have a mental health diagnosis? Yes No

If so, who and what is their diagnosis?

Who primarily raised you?

Were there any unusual or traumatic experiences for you as a child? Yes No

Date	Age	Event
_____	____	_____
_____	____	_____
_____	____	_____

Please list any significant losses you have experienced throughout your life and how you have handled them (coping mechanisms, skills, supports, defenses, etc.):

Living Arrangements

With whom are you currently living?

Are your living arrangements satisfactory or unsatisfactory? Why?

Marital History (if never married, please move down to the next section)

Current marital status _____

Name/age of spouse_____

Previous marriages? Yes No If yes, number of previous marriages: _____

Date(s) of divorce: _____

If currently married, what is your perception of your current marriage (include communication patterns, conflict resolution, sexual relations, etc.)?

List names/ages of each of your children. How would you describe your relationship with each one?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nutrition/Exercise/Sleep

Have you eating habits changed recently? Yes No

Has your weight fluctuated more than +/- ten pounds over the past year? Yes No

Do you ever feel as if your eating is out of control? Yes No

How often do you exercise? _____

How many hours of sleep do you receive on average? _____

Do you have problems falling asleep or staying asleep? Yes No

If yes, when did your difficulties begin and what are the primary causes of your sleep difficulties?

List of Symptoms

Please circle any of the following that have been bothering you lately:

Difficulty concentrating, remembering details, and making decisions

Fatigue and decreased energy

Feelings of guilt, worthlessness, and/or helplessness

Feelings of hopelessness and/or pessimism

Insomnia, early-morning wakefulness, or excessive sleeping

Irritability Restlessness

Loss of interest in activities that were once pleasurable

Overeating or appetite loss

Persistent aches or pains Headaches Digestive problems

Persistent sad, anxious, or "empty" feelings

Racing heart Dizziness Excessive sweating Difficulty breathing

Thoughts of suicide or suicide attempts

Excessive worry that is difficult to control

Edginess or restlessness Obsessions or compulsions

abused as child alcohol use pornography ambition

anger anxiety being a parent bullying career choices

children impulsivity confidence depression

divorce substance abuse eating problem education

energy (hi/low) fears finances friends guilt

health problems inferiority feelings loneliness making decisions

marriage memory nervousness nightmares

obsessive thinking overweight panic attacks phobias

relationships sadness self-esteem sexual problems

short temper shyness stress work

Other symptoms not listed: _____

<u>Support System</u>
Who can you count on for support? Circle as many as apply.

Parents Spouse Siblings Employer Church Pastor Friend Neighbor Extended Family

Self-help Group Community Services Co-Worker Medical Doctor Therapist Other_____

Financial Situation

Briefly describe your financial situation.

Do you currently have concerns about your financial situation? Yes No

Faith/Religious Beliefs

What is your current religious background? _____

Do you currently attend a church, synagogue, mosque? Yes No

If so, which one and how often? _____

What role does your faith have in how you handle life challenges?

Work Adjustment History

Describe your current job/career.

How many hours per week do you work?

Educational History

Highest level of education achieved:

How did you perform academically?

Are you currently in school? Yes No If yes, what level/degree pursuing?

Personal

If you had two days to yourself, what are the things you would choose to do with your time?

Who do you spend most of your time with?

List your current strengths and growth areas:

Strengths **Growth Areas**

Other

Is there anything else that is important for me to know that you have not written about on any of these forms? If so, please share with me here.

Child/Adolescent Intake Form

I look forward to meeting with you and your child in the near future. In order to achieve optimum results through the counseling process, it is important to gather a significant amount of information to provide me with a picture of who your child is. If there are any questions you do not feel comfortable answering or would rather discuss in person, please feel free to leave it blank. If you have any questions, please let me know.

Child's full name:_____

Date of birth:_____ Gender:_____ Race/ethnicity:_____

Presenting Issues

Adult providing intake information: _____

How did you learn about LifeCare? _____

Please describe the primary reasons why you are pursuing counseling for your child. Please explain in detail, including your child's emotional and behavioral symptoms, as well as their intensity, frequency and duration:

Please state what you hope to achieve through counseling:

Please explain in detail any high-risk behaviors your child may be currently engaging in, or has engaged in, in the past (e.g., drug/alcohol use, sexual activity, running away, self-harm or suicidal ideation/action, etc.):

Please list your child's strengths or areas of success:

What are specific growth goals you have for your child:

If applicable, please list activities outside of school in which your child is actively involved (e.g., sport teams, church, etc.):

Please state all methods of redirection and discipline you use with your child, how your child responds to discipline, and if these methods have been successful:

Family Dynamics

Please list all disorders and conditions that are known in your child's biological family, including those of siblings, parents, grandparents, aunts, uncles, cousins, etc. (e.g., depression, anxiety, substance abuse/addiction, genetic disorders, neurological disorders, emotional/physical/sexual abuse, antisocial/criminal behavior, etc.):

Please state if there have been any recent stressors or changes in your environment which may be affecting your child (e.g., divorce or marital problems, death in the family, move to a new home / school / or neighborhood, etc.):

Parent Demographics

Current caretakers:

Mother's name
Date of Birth
Address
Home/work/cell phone numbers
Email
Occupation / Employer

Father's name
Date of Birth
Home/work/cell phone numbers
Email
Occupation / Employer

Please list siblings and/or all other individuals living in your child's home, who these individuals are in relation to your child, and each individual's age:

Child's Developmental and Medical History

Please list any problems during pregnancy and/or delivery of your child:

Please state if your child was exposed to in utero stressors (e.g., mother under emotional stress, mother smoking cigarettes, drinking alcohol or having abused drugs while pregnant, etc.):

Please classify your child's early temperament (e.g., easy, quiet, stubborn, shy, difficult, over active, etc.):

Please list any developmental delays or problems your child had as an infant and toddler (e.g., weaning, walking, sitting up alone, toilet training, talking):

Please list any problems your child has had, or currently has, with sleep, eating, or elimination/ toileting (e.g., constipation, soiling undergarments):

Please list any sensory difficulties that your child may be displaying (e.g. textures of clothing/food, sensitivity to sound/light, etc.):

Please list any chronic medical conditions your child currently has, or has had, in the past (ear infections, allergies, etc.):

Please list all of your child's emergency hospital visits, hospitalizations, and surgeries, including child's age, reason, and length of stay:

Please list any medications/dosage your child routinely takes, or has taken in the past, and the reason for this medication:

Please list your child's pediatrician with telephone number:

Please state the last time your child had a physical exam:

On average, how many hours of sleep per night is your child getting:

Child's School History

Please state your child's current grade, school, and primary teacher:

Current academic performance:

Please explain any identified special needs your child has at school (e.g., emotional, social, learning disabilities) and any interventions currently in place:

Please list all current providers/agencies your child is involved with, specifically identifying the name of provider, telephone number, and what services you and/ or your child are receiving:

Please list any former providers/agencies who have seen you and/or your child, including the diagnoses your child received, when these services were received, and from whom received:

Any other additional information that would be important to know:

Please include any supporting documents that may be helpful to add to their file (adoption placement paperwork, IEPs, 504 plans, OT records, other health records, etc.)