SHAPING

Today's Date: ____ /____ /_____

Name: _____
First Middle Last

Spouse: _____
First Middle Last

Home Address: _____
Street Apt/Suite #

_____ _____ _____
City State Zip Code

Home Telephone #: ( ) _____ - _____ Cell: ( ) _____ - _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

_____

Your birth date: ____ /____ /_____ Age: _____

Spouse's birth date: ____ /____ /_____ Age: _____

Circle any that currently apply:

Marital Status: Single Married Separated Divorced. Widowed Length of time: _____

Employed: Yes / No Student: Full-time / Part-time. School: _____

Any speech, hearing, or visual-functioning needs? Yes / No

Faith-Based Counseling: Yes / No Religious Affiliation: _____

For office use only

Acct # _____ ICD Code _____ CPT(s) _____

AUF _____

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Items marked with an asterisk (*) are essential for most insurance companies to process your claim.

***Insured's ID#** _____ Primary Ins. Company Name: _____

***Name of insured person:** _____
Last First MI

Client relationship to insured (circle one): Self Spouse Child Other

Insured's Address: _____
Street Apt/Suite #

_____
City State Zip Code

Insured's Home Tel. #: ( ) _____ - _____ Work ( ) _____ - _____

***Insured's birth date:** ____ /____ /_____

Deductible? Yes / No Amount $ _____

Secondary Ins. If there is one: _____

(We submit to insurance as a **courtesy to you**, it is ultimately **your** responsibility to know and understand your coverage and benefits; A copy of your current insurance card must be on file at all times)

If someone other than the client will be responsible for the payments (ex. parent, relative, organization)

Name: _____ _____
First MI Last Relationship to patient?

Address: _____
Street Apt/Suite #

_____ _____ _____
City State Zip Code

Home Tel. #: ( ) _____ - _____ Work: ( ) _____ - _____ Cell: ( ) _____ - _____

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Occupation: _____ Place of Employment: _____

Address: _____ Duration of Employment: _____

Last Grade Completed: _____

Religious Preference: _____

Names of people living in your home	Relationship	Age	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Names and ages of children *NOT* living in your home

_____	_____	_____	_____
_____	_____	_____	_____

Who is your primary care physician? _____
Name

_____ ( ) _____ - _____
Address Phone

Current medical problems: _____

_____

_____

_____

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Current Medications (use back of sheet if more space needed):

Prescribing MD	Medication Name	Date Prescribed	Dosage	Side Effects	Refills
_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	Y / N

Previous psychological counseling: _____
Therapist Name City State

When:_____

Problems:_____

Duration of Treatment:_____

Results: _____

Please briefly describe what brought you in for treatment:

Have any anniversaries of important or stressful events in your life occurred recently or are any due to occur soon?

What solutions or efforts have you tried to solve the problems that have brought you here?

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Who gave you our name or referred you here? _____
Name

_____ ( ) _____ - _____
Address Phone

I, the undersigned, hereby authorize the release of information concerning me to:

1. My physician (or other physician in his/her stead) if consultation becomes necessary.
2. My insurance company, if claim forms are to be filled out and filed.
3. The professional person who referred me, simply stating that I have made contact.

Signature: _____ Date _____

Spouse/Guardian: _____ Date _____

Witness _____ Date _____

SHAPING

Shaping Professional Counseling Policies and Procedures

The purpose of Shaping Professional Counseling (SPC) mental health treatment is to help you achieve your goals and overcome any obstacles that led you to seek counseling with SPC. You are encouraged to work with your counselor in the development of your treatment plan and be informed of any new modes used within your treatment process. The associated risks of mental health counseling are limited. You may experience some emotional difficulty, which your counselor will do their best to help you work through. The benefits to be gained from counseling are vast. Some potential benefits of counseling are an improved outlook on life, more effective coping skills, greater understanding of yourself, and better communication tools that will not only have positive effects on your relationships, but through many spheres of your life.

1. **Participation in Counseling**

    a. As a client of SPC you are not required to accept treatment from SPC at any time. You have the right to decline part or all of your treatment, including withdrawal from our services should you not be willing to participate.

    b. The Counselor - client relationship is a professional relationship engaged in for the purpose of working on client - identified goals, using the professional and academic experience of the counselor and the relationship built in sessions. While this relationship may be significant, it is in no way of a personal or romantic nature.

    c. While your counselor will do their best to assist you, counseling is a collaborative process, and there are no guarantees that you will be satisfied with your treatment.

2. **Informed Consent for One Medical Record**

    I understand and consent to SPC having one medical record for me. I understand that every counselor and/or intern who provides treatment for me at SPC will have access to all clinical notes in my clinical record.

3. **Informed Consent for Research**

    There may be opportunity in the course of your treatment to participate in research or outcome based metrics. You are not required to participate and there will be no direct or implied deprivation or penalty for refusal to participate.

4. **Release of Information Form**

    All information obtained/derived during the course of treatment is fully confidential; disclosures you share with your therapist are confidential unless you have SIGNED a consent form to release part or all of the information.

    If you desire SPC to either release or obtain information from a specific individual or agency, a Release of Information form must be obtained, signed, and dated. A fee may be associated with providing information to a specific individual or agency.

    Exceptions to this guideline include instances when:

        a. The client is a clear danger to (a) themselves or (b) others.

b. When a client discloses abuse or neglect that occurred as a minor (client is either currently a minor or past abuse occurred when client was a minor).

c. If there is any suspected abuse to a child or vulnerable adult, or

d. When judicially required (e.g. subpoena).

5. **Telephone Calls**

Occasions may arise when you need to talk to your counselor in between normally scheduled sessions. If you leave a message with your counselor, they will make every effort to respond in a timely manner. Any consultation by telephone made between scheduled sessions will incur a charge to the client. If there is a life- threatening emergency, call 911 or go immediately to your local Emergency Room.

6. **Length of Session**

Depending on what your insurance allows and authorizes, the psychotherapy sessions are varied in length between 38 and 53 minutes in length. It is to your benefit to arrive a few minutes in advance of the appointment time. Since your counselor has additional sessions scheduled after yours, the session must end at the appointed time regardless of your arrival time.

7. **Fees and Payment**

a. Our current fee per session is $130 for individual therapy sessions and $150 for marriage/couples therapy sessions.

b. All payment is due at the time services are rendered. Payment may be made in the form of cash, check, or credit. If you choose to pay by check, please be prepared to supply a form of ID (e.g. driver's license) and make checks payable to Shaping Professional Counseling.

c. If any or all outstanding balances are not paid in a timely manner, SPC reserves the right to release a client's name and address to a collection agency. Also, a monthly fee of 2% will be charged for these balances until they are paid in full.

d. There are additional fees for requests for additional medical records, court documents or any other requests outside of the counseling relationship. Please refer to a separate Legal Representation document for more information on fees and rates for SPC services.

e. If you are Health Savings Account benefits from your employer, you may request a receipt to verify any and all of your therapy services.

8. **Insurance**

Shaping Professional Counseling is in network with all CareFirst BlueCross BlueShield health insurance plans. If you do not have CareFirst BlueCross BlueShield health insurance, you will be subject to a fee for service model. Upon request, we can provide a document verifying therapy services to your insurance, for reimbursement purposes.

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9. **Social Media Policy**

   Social Media platforms (e.g. Facebook, Instagram, Snapchat, etc.) are not appropriate mediums for communication with your counselor. Your counselor will not accept any requests for a social media connection with a current client. Please communicate with your counselor via their approved email address and/or phone number when communicating outside of session.

10. **Cultural Considerations**

    SPC seeks to provide culturally appropriate counseling services to all of our clients. If clients require a translator or interpreter in order to understand the communication from their counselor, SPC will make every necessary effort, within reason, to accommodate the clients for the purpose of clinical counseling, as required by the ADA.

11. **Complaints to Board**

    You have a right to contact your counselor's State Professional Licensure Board. We trust that your involvement within Shaping Professional Counseling will be helpful to you. If you have any questions regarding these arrangements or other aspects of your relationship with us, please discuss them with your therapist or his/her Clinical Supervisor.

12. **Cancellations and Missed Appointments**

    When an appointment is scheduled, that time is reserved for you. If the appointment is missed or canceled without sufficient notice, the therapist is unable to make use of that time. It is your responsibility to give at least 24 hours' notice if you must miss or cancel an appointment. Therefore, a cancellation fee of $60 will be assigned every time an appointment is missed or canceled with less than 24 hours' notice (does not apply to Medicaid patients). This fee is assessed regardless of the reason for missing or canceling the originally scheduled appointment. Repeated missed appointments or cancellations may affect the retention of your allotted time slot.

My signature certifies that I have thoroughly read, understand and agree to all of the Policies and Procedures of Shaping Professional Counseling listed above. I have been given a copy of the Policies and Procedures.

Client's Signature: _____ Date: ____ /____ /_____

SHAPING

HIPPA Privacy Notice of Shaping Professional Counseling

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of your individual identifiable health information; this is, Protected Health Information (PHI), as that term is defined in the HIPAA under Information

THE EFFECTIVE DATE OF THIS NOTICE IS April 3, 2023. Shaping Professional Counseling (SPC) is required to follow the terms of this Notice until it is replaced. SPC may make changes to the terms of this Notice at any time. **Upon your request**, we will provide you with a copy of the current Notice. SPC reserves the right to make the changes apply to your PHI maintained in our files before and after the effective date of the new Notice. The following is a general description of how Federal and State law permits us to use and disclose your PHI

Purposes for which Shaping Professional Counseling May Use or Disclose Your Mental Health Information with your Consent

Shaping Professional Counseling may request your consent for the use and/or disclosure of your PHI for treatment, payment or health care operations as described below:

- *Treatment*: SPC will use and disclose your PHI to provide, coordinate, or manage your mental health care and any related services. SPC may disclose your PHI to physicians, therapists, other mental health providers, or other health care providers with SPC who are treating you or assisting in your diagnosis, treatment, or recovery.

- *Payment*: Your PHI will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one third-party payer is responsible for payment for your health care, SPC may disclose your PHI to more than one health plan and those health plans may share your PHI with each other. Your PHI may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.

- *Mental Health Care Operations*: SPC may use or disclose as needed your PHI in order to support delivery of mental health care services. SPC may call you by name in the waiting area. SPC may use or disclose your PHI, as necessary, to contact you to schedule an appointment or remind you of your appointment.

- *Business Associates*: SPC may share your PHI with third party business associates who perform various administrative services. Whenever an arrangement between a business associate and SPC involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

- *Health Care Services*: Your PHI may be used and disclosed to contact you and to give you PHI about treatment alternatives or other health benefits and services that may be of interest to you.

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Uses and Disclosures With Your Verbal Consent

Your PHI may be disclosed to a family member, friend, or other person designated by you or as designated by the law, if you verbally agree.

Uses and Disclosures with Your Written Authorization

Except as provided below, your PHI will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your PHI for a purpose that is not described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the PHI SPC maintains, unless SPC has taken action in reliance on your authorization.

Uses and Disclosures Without Your Consent

- As required by law;
- To comply with legal proceedings, such as a court or administrative order or subpoena;
- To law enforcement officials for limited law enforcement purposes;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To avert a serious threat to your health or safety or the health or safety of others;
- To a governmental agency authorized to oversee the mental health care system or government programs
- To federal officials for lawful intelligence, counterintelligence, and other national security purposes
- To public mental health authorities for public health purposes.

Your Rights

You may make a written request to SPC to do one or more of the following concerning your PHI:

- Put additional restrictions on use and disclosure of your PHI.
- Communicate with you in confidence about your PHI by a different means than SPC is currently doing.
- See and get copies of your PHI.
- Receive a list of disclosures of your PHI that SPC has made for certain purposes for six (6) years prior to your request (after April 14, 2003), with certain exceptions permitted by law, which includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact us at the address below. In certain instances, SPC is not required to agree to your request. SPC will give you necessary information and forms for you to complete and return to request your Information. SPC is permitted, by law, to charge you a fee for copying any documents requested in accordance with your rights as listed above. (Fee $1.00 per page.)

Complaints

If you believe that Shaping Professional Counseling violated your privacy rights, you have the right to complain to SPC or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with SPC at the address below. An individual must file a complaint within 180 days of when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. Shaping Professional counseling will not retaliate against you if you choose to file a complaint.

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Contact Address:

Shaping Professional Counseling
15630 Old Columbia Pike, Suite 178
Burtonsville, MD 20852

USDHHS
200 Independence Ave. SW Washington, DC 20201

or call: 1-877-696-6775

As a client of Shaping Professional Counseling, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by SPC.

Client Name or Guardian (Print): _____

Client's Signature: _____ Date: ____ /____ /_____

SHAPING

Telehealth Consent

I, hereby consent to engage in Telehealth. I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the [Informed Consent Form or Name of Payment Agreement Form].

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance. I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

Client's Signature: _____ Date: ____ /____ /_____

SHAPING

Shaping Professional Counseling Confidential Child Intake Packet

I, _____ give Shaping Professional Counseling and _____ permission
(Parent/Guardian) (Provider)

for treatment for: _____
(Child's name)

Confidentiality Statement

I, _____ and _____ understand the limits to confidentiality and
(Parent/Guardian) (Child)

have been provided with a copy of this Statement.

For the Parent/Guardian: The right to confidentiality is maintained with two exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others, including your child

For the Child: The right to confidentiality is maintained with three exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others.
3. The professional has reason to believe that someone or something is harming you, including your parents.

Additional disclosures at the Parent's request:

_____

_____

_____ _____ _____
Provider **Parent/Guardian** **Date**

_____
Counselor

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Shaping Professional Counseling
Credit Card Authorization Form

Client Name: _____

Counselor: _____

Date of Service: ____ /____ /_____

Charge Amount: $ _____

Specify Type of Credit Card:

☐ Credit Card

☐ Debit Card

☐ Flex Spending/HSA Card

Name on Card:_____

Billing Address: _____

Cardholder's Phone Number: _____

Credit Card #: _____

Expiration Date: ____ /_____

Security Code: _____

I, _____, authorize Shaping Professional Counseling to bill my credit card for the amount indicated above and/or for any ongoing balances on my account.