Carolina Counseling Professionals
A center for hope and healing

Client Name: _____

Date: _____

203 Central Park Lane, Suite A ♦ Seneca, SC 29678

New Client Registration

CLIENT INFORMATION

Client Full Name _____ Preferred Name _____

Client Birth Date _____ Age _____ Social Security # _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Preferred Number to Call: Home Work Cell

How late can calls be returned? _____ Do you want to receive and respond to text messages? Yes No

Referred By _____

Marital Status: Single Married Widowed Divorced Other _____

Employment Status: Employed Full-Time Student Part-Time Student Retired

Relationship to Insured: Self Spouse Child Other _____

GUARANTOR INFORMATION (For Clients under 18, the Guarantor is financially responsible for any balance due)

Parent/Guardian Full Name _____ Preferred Name _____

Parent/Guardian Birth Date _____ Social Security # _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Preferred Number to Call: Home Work Cell

EMERGENCY CONTACT INFORMATION

Primary Contact Name _____ Relationship_____

Home Phone _____ Cell Phone _____

Secondary Contact Name _____ Relationship_____

Home Phone _____ Cell Phone _____

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INSURANCE INFORMATION (if applicable)

Name of **Primary** Insurance _____ Member ID _____

Group/Policy # _____ Insurance Phone # _____ Effective Date _____

SUBSCRIBER INFORMATION (Person who carries the insurance) **[ ] Check here if same as the patient**

Name _____ Birth Date _____ Social Security # _____

Phone # _____ Email _____

Name of **Secondary** Insurance _____ Member ID _____

Group/Policy # _____ Insurance Phone # _____ Effective Date _____

SUBSCRIBER INFORMATION (Person who carries the insurance) **[ ] Check here if same as the patient**

Name _____ Birth Date _____ Social Security # _____

Phone # _____ Email _____

A copy of your insurance or Medicaid card is needed at the time of service. Please read the following carefully and sign below.

Assignment of Benefits and Release of Information

I give permission to Carolina Counseling Professionals, LLC and billing staff to send required information to my insurance company and/or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will be responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at 100%. I understand that my insurance and/or EAP does not cover the cost of missed appointments.

_____ _____

Signature of Patient/Responsible Party Date

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1. Please briefly describe the problem or situation which led you to seek counseling services.

_____

_____

_____

2. What are your goals for therapy?

_____

_____

_____

3. Are there any circumstances we should be aware of?

_____

_____

_____

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PRESENTING PROBLEM CHECKLIST

Circle the most appropriate answer:

Aggressive Behaviors: None Mild Moderate Severe

Appetite Disturbance: None Mild Moderate Severe

Bingeing/Purging: None Mild Moderate Severe

Crying/Tearful: None Mild Moderate Severe

Depressed Mood/Sad: None Mild Moderate Severe

Difficulty Getting Out of Bed: None Mild Moderate Severe

Difficulty Making Decisions: None Mild Moderate Severe

Elimination Disturbance: None Mild Moderate Severe

Emotional Trauma Victim: None Mild Moderate Severe

Fatigue/Low Energy: None Mild Moderate Severe

Feeling Angry: None Mild Moderate Severe

Feeling Empty: None Mild Moderate Severe

Feeling Sad: None Mild Moderate Severe

Generalized Anxiety: None Mild Moderate Severe

Grief: None Mild Moderate Severe

Guilt: None Mild Moderate Severe

Hallucinations: None Mild Moderate Severe

Hopelessness: None Mild Moderate Severe

Hyperactivity: None Mild Moderate Severe

Irritability: None Mild Moderate Severe

Mood Swings: None Mild Moderate Severe

Need to Repeat Actions: None Mild Moderate Severe

Obsessions/Compulsions: None Mild Moderate Severe

Oppositional Behavior: None Mild Moderate Severe

Panic Attacks: None Mild Moderate Severe

Paranoid Thinking: None Mild Moderate Severe

Physical Trauma Perpetrator: None Mild Moderate Severe

Physical Trauma Victim: None Mild Moderate Severe

Poor Concentration: None Mild Moderate Severe

Poor Hygiene: None Mild Moderate Severe

Racing Thoughts: None Mild Moderate Severe

Sexual Dysfunction: None Mild Moderate Severe

Sexual Trauma Perpetrator: None Mild Moderate Severe

Sexual Trauma Victim: None Mild Moderate Severe

Significant Weight Change: None Mild Moderate Severe

Sleep Problems: None Mild Moderate Severe

Thoughts of Death: None Mild Moderate Severe

Trouble Concentrating: None Mild Moderate Severe

Worthlessness: None Mild Moderate Severe

Worried: None Mild Moderate Severe

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CURRENT MEDICATIONS:

Medication	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior or current psychiatric medications? Yes No

If yes, briefly explain: _____

_____

Who is your Primary Care Physician? _____

Are there any medical issues we should be aware of? Yes No

If yes, briefly explain: _____

_____

COUNSELING/PSYCHIATRIC HISTORY:

Have you or a member of your family received any counseling or psychiatric services in the past? Yes No

If yes, briefly explain: _____

_____

Have you or a member of your family had treatment for a psychiatric, emotional or substance use disorder? Yes No

If yes, briefly explain: _____

_____

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FAMILY HISTORY:

Describe your parent(s) and/or step-parent(s):

Parent's Name	Occupation	Education	Health	Marital Status

Describe Your Childhood Family Experience: *Please check one*

- ☐ Outstanding Home Environment
- ☐ Normal Home Environment
- ☐ Chaotic Home Environment
- ☐ Witnessed Physical/Verbal/Sexual Abuse
- ☐ Experienced Physical/Verbal/Sexual Abuse

Social Interaction: *Please check all that apply*

- ☐ Normal Social Interaction
- ☐ Very Shy
- ☐ Influenced by Peer Pressure
- ☐ Isolates Self
- ☐ Inappropriate Sex Play

Intellectual/Academic Functioning: *Please check all that apply*

- ☐ Normal Intelligence
- ☐ High Intelligence
- ☐ Underachieving
- ☐ Authority Conflicts
- ☐ Learning Problems
- ☐ Mild Intellectual Disability

Client's Current or Highest Education Level: _____

Emotional/Behavior Problems: *Please check all that apply*

☐ Animal Cruelty	☐ Easily Distracted	☐ Lack of Attachment
☐ Assaults Others	☐ Fire Setting	☐ Not Trustworthy
☐ Breaks Things	☐ Frequently Tearful	☐ Repeats Words of Others
☐ Chronic Lying	☐ Hyperactive	☐ Self-Injures
☐ Daydreams	☐ Immature	☐ Stealing
☐ Disobedient	☐ Impulsive	☐ Violent Temper

Other: _____

SUBSTANCE ABUSE HISTORY:

Substances Used: *Please check all that apply*

☐ Alcohol	☐ Cocaine	☐ Marijuana
☐ Amphetamines/Speed	☐ Crack Cocaine	☐ Nicotine
☐ Barbiturates/Downers	☐ Hallucinogens (LSD)	☐ PCP
☐ Caffeine	☐ Inhalants (Glue/Gas)	☐ Prescription

Substance Abuse Status: *Please check one*

☐ No History of Substance Abuse	☐ Active Abuse	☐ Early/Full Remission

Is there a family history of substance abuse? Yes No If yes, please explain _____

_____

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Scheduling and Cancellation Policy

Carolina Counseling Professionals, LLC requires a **24-hour notice** before your appointment to cancel or reschedule an appointment. Failure to comply with the 24-hour notice will result in a **$40 cancellation fee**. In rare instances, there may be exceptions to this fee. A voicemail or email to your provider is acceptable.

If you **No Show** two appointments in a row it is at the discretion of Carolina Counseling Professionals, LLC and/or the therapist to dismiss you from the practice.

_____ _____

Signature of Patient/Responsible Party Date

Fees, Payment and Insurance

If you are using insurance, it is your responsibility to contact your insurance to determine eligibility including deductibles, copays and co-insurance for mental health benefits. At the beginning of each session, we ask that you pay your copay, co-insurance and/or deductible. Carolina Counseling Professionals, LLC will bill your insurance for the remainder of the fee. We **do not** send monthly bills for client accounts. Please ask your provider should you need any information regarding your account.

_____ _____

Signature of Patient/Responsible Party Date

Phone Calls

Our general policy is to leave only our name and phone number when phone calls are returned. Please indicate your consent for our office to leave appointment changes, account information, insurance information, etc.

_____ (Initial) I authorize Carolina Counseling Professionals, LLC to leave information on my voicemail, text and/or email.

_____ (Initial) I do not authorize Carolina Counseling Professionals, LLC to leave information on my voicemail, text and/or email.

Emergencies

In the event of an emergency, please call 911 or proceed to your local emergency room.

Court Reports and Sessions

_____ (Initial) With very few exceptions, we do not attend court sessions. A court report can be written to bring to court. Depending on the length of the report, the normal charge is $150. If we are required to attend a court session, the hourly charge is $300 in addition, travel is $20 per 15 minutes.

Communication Policy

_____ (Initial) In the age of social media and electronic communication, there are no forms of electronic communication that can be guaranteed to be confidential. HIPAA does not consider cell phone communications confidential. As a result, we suggest that you limit our electronic communications to billing or scheduling issues. By initialing this consent, you agree to accept the risk of limited confidentiality for information transmitted via text or email.

_____ (Initial) Social media invitations or friend requests cannot be accepted by a therapist. If you choose to comment on a public site and identify yourself as a client, then you forgo your right to confidentiality.

_____ (Initial) If your therapist encounters you in a public setting, they will not acknowledge you in order to protect your confidentiality.

Confidentiality

Carolina Counseling Professionals, LLC is committed to making this a safe place for you to get help. To that end, we adhere to all legal protections of your confidentiality. Limitations include staff consultation, life-threatening behavior, child abuse, elder abuse and judge's order to release information. Good communication between us is vital to our ability to serve you well. Please tell us about any problems and/or questions that might arise. If you don't understand an answer or if new problems arise, let us know. We want to provide the best possible care for you and we need your cooperation to succeed. Please contact us if you have any questions or concerns.

In order to maintain the therapeutic integrity of the relationship with your child, it is required that you waive the right to subpoena clinicians of Carolina Counseling Professionals, LLC to court. Maintaining confidentiality is key to developing a therapeutic relationship with your child and is the reason for this policy.

Your signature below agrees to this policy.

_____ _____

Signature of Patient/Responsible Party Date