Nancy Conrad Ball Counseling & Consulting, PLLC
2307 W. Cone Blvd. # 280
Greensboro, NC 27408
336-272-0079 Office 336-907-8031 Fax

CLIENT DATA SHEET (Child) **PLEASE PRINT**

Today's date: _____ Referred by: _____

Child's name: _____ (as shown on insurance card)

Likes to be called (nickname): _____

Home address: _____

City _____State_____ Zip _____

Insurance Information: Insurance company name: _____

Policyholder name: _____Policyholder date of birth: _____

Parent/Guardian phones (circle preferred method of contact):

home_____ work _____Ext_____ cell _____
Parent/guardian email address: _____

Child's date of birth: mo_____ day_____ year_____ Age: _____

School: _____ Grade: _____ Grade Point Average: _____

FAMILY INFORMATION

Relationship (full name)		Place of Employment	Contact phone
Father	_____	_____	_____
Stepfather	_____	_____	_____
Mother	_____	_____	_____
Stepmother	_____	_____	_____
Guardian	_____	_____	_____

If parents are separated or divorced, who has custody? ____ Father ____ Mother
___Joint, please explain
_____
Adult household members:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Brothers & sisters (including half or step)

Name	Sex	Age	Date of Birth
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Religious Affiliation: _____

MEDICAL INFORMATION

Child's health care provider: _____ Date of last physical exam _____

May we communicate with your child's health care professional? Yes _____ No_____

Allergies, if any: _____

Health Problems: 1) _____ 2) _____

3) _____ 4) _____

Medications: 1) _____ 2) _____

3) _____ 4) _____

DEVELOPMENTAL HISTORY

Prenatal complications: yes_____ no_____ Birth complications: yes _____ no: _____

Birth Weight: _____

Please write age at which child: Walked _____Toilet trained _____ Combined Words _____

Previous counseling: Date(s) _____, _____;

Therapist(s) _____, _____

Insurance and Payment Information

All professional services rendered are charged to the client or the client's parent/guardian (if child is a minor). I understand that this office files my insurance as a courtesy but the bill is my responsibility. I am responsible for all fees, including services not covered by insurance, unless expressly noted otherwise. It is customary to pay for services when rendered unless arrangements are made in advance.

Who is financially responsible for this bill:

_____

Name Address City State Zip

Release of Information

I hereby authorize Nancy Conrad Ball, M.Ed., LPC to release any information necessary to process insurance claims concerning my diagnosis and treatment and I authorize payment of medical/psychological benefits to Nancy Conrad Ball, M.Ed., LPC.

I understand that Nancy Conrad Ball, M.Ed., LPC is ethically and legally required to report to legal authorities, information I or my child gives them about ongoing child neglect or abuse and imminent physical danger I or my child presents to self or others.

I have read, understand and accept the above terms and conditions.

_____ _____

Parent or Guardian signature Date

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Youth Wellness Assessment

Today's date: _____

Last Name: _____First Name: _____Date of Birth: _____

Your relationship to child: ____ Mother ____ Father ____Stepparent _____Self _____ Guardian/other

Completing this brief questionnaire will help us provide services that meet your child's needs.

Which best describes your child:	**Not at all**	**A little**	**Somewhat**	**A lot**
1. Destroys property				
2. Is unhappy or sad				
3. Behavior causes school problems				
4. Has temper outburst(s)				
5. Worrying prevents him/her from doing				
6. Feels worthless or inferior				
7. Has trouble sleeping				
8. Changes moods quickly				
9. Uses alcohol				
10. Uses illegal drugs				
11. Is restless, has trouble staying seated				
12. Engages in repetitious behavior				
13. Worries about almost everything				
14. Needs constant attention				
15. Bullies others				
16. Is being bullied by others				
17. Weight loss/gain as a result of eating habits				
18. Concerns with peer/social relationships				
19. Use of video games & Internet				

How much has your child's problems caused:	**Not at all**	**A little**	**Somewhat**	**A lot**
1. Interruption of personal time				
2. Disruption of family routines				
3. Less attention paid to family members or others				
4. Disruption or upset of relationships within the family				
5. Disruption or upset of your family's social activities				
6. Any family member to suffer mental or physical illness				

7. How many days in the past week was your child's usual routine interrupted by their problems? _____ days
8. In general, would you say your child's health is: ____ excellent ____very good ____ good ____ fair ____poor
9. In the past six months, how many times did your child visit a medical provider? ____none ____1 ____2-3 ____4-5 ____6+
10. In the past month, how many days were you unable to work because of your child's problems? ____days
11. In the past month, how many days have you had to cut back on how much you got done because of your

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CONSENT FOR RELEASE OF MENTAL HEALTH INFORMATION

This form is used to be able to discuss or release information to your (or your child's) primary care provider (PCP) or psychiatrist, in order to coordinate treatment.

If you wish for information to be released to the PCP or psychiatrist, please fill in the name of that provider, check the authorization line, sign and date the form.

If you DO NOT wish for information to be released to the PCP or psychiatrist, check by the decline line and sign and date the form.

Patient Name: _____ Date of Birth:_____mo _____day _____year

Mental Health provider name: _____

PCP or psychiatrist name: _____

PCP or psychiatrist address, city, state:
_____

PCP or psychiatrist phone: _____

____ I authorize the release of relevant treatment information to the PCP or psychiatrist named above. I understand that these records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. My consent may be revoked at any time and expires one year from the date signed.

____ I decline the release of treatment information to my PCP or psychiatrist.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Relationship to Patient

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Professional Disclosure Statement

I am pleased that you have selected me as your counselor. The following information is designed to inform you of my background and to ensure your understanding of the nature of the professional therapeutic relationship, your rights as a client and office policies.

I received a Master of Education degree in mental health counseling from the University of North Carolina at Greensboro in 1992. I am a Licensed Professional Counselor (LPC #769) and a National Certified Counselor (NCC #27975). I was the recipient of the UNC-G Department of Counseling and Development Distinguished Practitioner award and the Chi Sigma Iota Counseling Academic and Professional Honor Society Outstanding Practitioner award.

PROFESSIONAL SERVICES
My services include individuals, couples, & family counseling for adults & adolescents. I was previously a partner with Triad Counseling & Clinical Services, LLC for 17 years and employed by Psychological Services of the Triad for 3½ years. My therapeutic approach reflects my training in family systems, developmental & cognitive-behavioral, insight oriented, and energy psychology. My special interests include anxiety and stress management, depression, grief and loss, marriage counseling and relationship concerns, separation, divorce, child custody and stepfamily issues, communication, conflict resolution and anger management, women's issues, and spiritual concerns.

CONFIDENTIALITY
I respect your confidentiality. In accord with professional ethics and HIPAA (Federal Compliance Regulations), a minimum amount of necessary information about you will be released for treatment, payment and healthcare operations. I may at times consult with peers about aspects of certain cases but will only identify you as a client in the following situations:

If you have given signed consent to discuss your case with another professional or family member.
If you report an imminent intention to seriously harm yourself or someone else.
If you reveal ongoing physical, sexual abuse or neglect of children, the elderly, or disabled persons.
If I am court ordered by a Judge or subpoena to release information.

EXPLANATION OF DUAL RELATIONSHIPS
Although sessions are psychologically intimate, the therapeutic relationship is professional, not social. It is important that the professional relationship be based on respect, safety, and trust. Therefore, it is in your best interest that contact with me be limited to counseling sessions or telephone conversations necessary to your therapy. It is not appropriate to extend social invitations or gifts or to relate in any other way that is outside the professional context of your therapy. These limits are designed with your welfare in mind and allow for all efforts to be directed towards your concerns.

LENGTH OF SESSIONS/MISSED APPOINTMENTS/CANCELLATIONS
Therapy sessions are typically forty-five (45) to sixty (60) minutes in duration.
To cancel an appointment please give **AT LEAST** 24-hour notice. There is no charge for sessions cancelled twenty-four (24) hours in advance**, IF LESS THAN 24 HOURS THE FULL FEE FOR THAT SESSION MAY BE BILLED. Insurance companies do not reimburse missed appointments. If no one is available to take your call, you may leave a message 24 hours a day at 336-272-0079.** If a cancellation occurs due to unavoidable circumstances, please discuss this matter with me.

FEES/METHODS OF PAYMENT
The fee for professional services is due when the service is rendered. The initial fee for individual psychotherapy is $150.00. Standard fee for individual therapy is $125.00 per fifty minute session. Cash, personal checks, MasterCard or Visa are acceptable for payment.

INSURANCE
Our office will file insurance claims on your behalf. If you have a deductible it is our policy to collect the entire fee for the initial session and any subsequent sessions until your deductible has been met, you may pay your portion of the fee thereafter. If you prefer to file for insurance reimbursements to be paid to you instead, you will need to pay the full fee at the time that services are rendered. Should your insurance program have special arrangements, please discuss this at your initial appointment.

Be aware that filing for insurance requires a diagnostic statement to be placed in your permanent insurance records. The forms must be signed by you in order to authorize the release of confidential information. If you wish to be informed of the diagnosis before it is submitted to your health insurance company, please make me aware and I will more fully discuss the diagnosis with you.

OFFICE STAFF HOURS
The office manager's hours are 11:15am to 5:00pm, Monday through Thursday and 9:45am – 12:00pm on Fridays. Inquiries about accounts and insurance should be directed to her should you have a concern.

COMPLAINT PROCEDURES
If you are dissatisfied with any aspect of your counseling experience with me, please inform me immediately. If you think that you have been treated unfairly or unethically and you have not been able to resolve the problem, you can contact The North Carolina Board of Licensed Professional Counselors at P.O. Box 1369, Garner, NC, 27529-1369, or (919) 661-0820 for clarification of client rights or to lodge a complaint.

To indicate that you have read and understand the information presented to you, your signature will signify your consent. Please sign and date this form. A copy will be returned to you, and one will be kept by this office in your confidential records.

_____ _____
Nancy C. Ball, M.Ed., LPC, NCC Client's signature

_____ _____
Date Date

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CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & ACKKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information" or PHI), excluding psychotherapy notes, by Nancy Conrad Ball Counseling & Consulting, PLLC (Provider) in order to carry out treatment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except in special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my medical/mental health records, although I understand the Provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a "reviewing official." A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my medical/mental health records, although I understand the Provider has the right to deny such request. I have the right to request an accounting of disclosures of my PHI for purposes other than TOP and those for which I provided authorization. I may submit a written privacy complaint to 2307 W. Cone Blvd. Suite 280 Greensboro, NC 27408 or to the U.S. Secretary of the Department of Health and Human Services, without any action being taken by the Provider against me without any change in my treatment.

Provider reserves the right to change the terms of its Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed, I may obtain a copy of the revised Notice by requesting a copy.

I retain the right to request that the Provider further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Provider is not required to agree to such requested restrictions; however, if the Provider does agree to by requested restriction(s), such restrictions are then binding on the Provider.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Provider in writing. The revocation shall be effective *except* to the extent that the Provider has already taken action in reliance on the Consent.

The Provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the Provider is required by law to treat individuals). If I (or authorized representative) sign the Consent portion and then revoke Consent, the Provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Provider is required by law to treat individuals).

I _____ **CONSENT** TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I _____ **DO NOT CONSENT** TO THE RELEASE FOR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I _____ HAVE HAD AN OPPORTUNITY TO REVIEW THE PROVIDER'S NOTICE OF PRIVACY PRACTICES.

Date: _____ _____
Signature of Patient (or authorized representative)

_____
Please Print Name

Representative's Authority to act on behalf of the Patient: _____