

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

Client Data Sheet (Adult)

PLEASE PRINT

Date: _____ Referred by: _____

Name: _____ Nickname: _____

Date of Birth: mo _____ day _____ year _____ Age _____

Home address: _____

City State Zip _____

Phones: home _____ work _____ cell _____

Email address _____ Preferred callback number (circle): H W C

Occupation: _____ Employer: _____

Business Address: _____

City State Zip _____ How long in present job? _____

Who may we contact in case of emergency? Name _____

Phone (home) _____ Phone (other) _____ Relationship _____

Current relationship status (check one): ___ Single; ___ Married (date) _____

Live-in relationship (date) _____ Separated (date) _____

Divorced (date) _____ Widow/er (date) _____

Spouse/partner name _____ Date of Birth _____ Age _____

Occupation of spouse/partner _____ Employer _____

Previous marriages/live-in relationships:

1st from _____ to _____ 2nd from _____ to _____ 3rd from _____ to _____

Children:

Name	Sex	Age	Place of Residence
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

What religion were you brought up in? _____ Religious Preference Now _____

Where did you live for the 1st 15 years of your life? (city and state) _____

Education (highest level completed) _____

Parents living together? ___ yes ___ no, because of _____(death, divorce, etc)
If parents not living together, is father remarried? ___yes___no, mother remarried?___yes___no_

Brothers & Sisters (including half or step): Name, Sex, Age, Date of Birth & Hometown

_____	_____
_____	_____
_____	_____

Family History of Mental Health (relative, diagnosis & year): _____

Family History of Chemical Dependency (who & year): _____

Personal Health Problems (diagnosis & year): _____

Personal Medications _____

Hospitalizations (diagnosis & year): _____

Previous counseling, type(s) & date(s) _____

Name of counselor(s) & location(s) _____

Insurance and Payment Information

All professional services rendered charged to the client. 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 the bill:

_____	_____	_____	_____
Name (if different from client)	Address	City	State Zip

Name of Insurance Policyholder

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. 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 legal required to report to legal authorities information I give about ongoing abuse of children, disabled and elderly persons and imminent physical danger I present to myself or others.

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

Client signature

Date

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Adult Wellness Assessment

Last Name: _____ First Name: _____

Date of Birth: _____ Today's Date: _____

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can. Please check the box that best describes your answer.

How much are you bothered by the following?

	Not at all	A little	Somewhat	A lot
1. Nervousness or shakiness				
2. Feeling sad				
3. Feeling hopeless				
4. Feeling everything is an effort				
5. Feeling little interest in things				
6. Heart pounding or racing				
7. Difficulty with sleep				
8. Feeling fearful				
9. Difficulty at home				
10. Difficulty socially				
11. Feeling angry or irritable				
12. Eating difficulties				
13. Difficulty at school or work				
14. Sexual difficulties				
15. Internet and/or social networking				

If you would like to explain any of the above in greater detail please do so here:

How much do you agree with the following?

	Not at all	A little	Somewhat	A lot
1. I feel good about myself				
2. I can deal with my problems				
3. I am able to accomplish the things I want				
4. I have friends or family that I can count on for help				

Please answer the following questions:

- In general, would you say your health is ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor
- Please indicate if you have a serious or chronic medical condition. _____
 ___ Asthma ___ Diabetes ___ Heart Disease ___ Back pain or other Chronic Pain ___ Other
- In the past 6 months, how many days were you unable to work because of your physical or mental health? (Answer only if employed) _____ Days
- In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? _____ Days
- In the past week, approximately how many drinks of alcohol did you have? _____
- In the past month have you felt you ought to cut down on your drinking or drug use? ___yes ___no
- In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ___yes ___no
- In the past month have you felt bad or guilty about your drinking or drug use? ___yes ___no

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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, Visa or Discover credit cards 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 to 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

CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & ACKNOWLEDGEMENT 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: _____

For Office Use only: Acknowledgement of Privacy Practices was not obtained because: