Gregory R. Fox, LCMHC
5500 McNeely Drive, Suite 101
Raleigh, NC 27612
(919) 424-1937
gregoryfoxlpc@gmail.com
www.ColWenCounseling.com

INITIAL CONSULTATION FORM

Date: _____

CONTACT INFORMATION:

First Name: _____ Last Name: _____

Date of Birth: _____ / _____ / _____

Address: _____ City: _____ State: _____

Phone: _____ Mobile: _____

☐ By checking here, I authorize Gregory R. Fox, LCMHC, ColWen Counseling Services PLLC to contact me at the above phone number(s).

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION:

Insurance Company: _____

Insurance Co. Address: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

CLINICAL INFORMATION:

Reason Seeking Consultation: _____

Previous Mental Health Services: YES or NO If yes, when: _____

Medical Conditions: _____

Please List Current Medications:	**Are you Taking as Prescribed?**
	YES or NO
	YES or NO
	YES or NO
	YES or NO

Please use the back of this page to list additional medications.

Alcohol Consumption:

- ☐ Daily
- ☐ Three or more times a week
- ☐ Occasionally
- ☐ Never

Illicit Drug Use:

- ☐ Daily
- ☐ Three or more times a week
- ☐ Occasionally
- ☐ Never

Are you currently employed?	YES or NO
Do you currently have a support network (family/friends)?	YES or NO
Have you been experiencing any general sadness or depression?	YES or NO
Have you been experiencing any anxiety or difficulty focusing and concentrating?	YES or NO
Are you currently or recently been having thoughts to harm yourself or anyone else?	YES or NO
Have you experienced any recent life changes?	YES or NO
Do you have a family history of mental health issues?	YES or NO

What is it that you hope to accomplish during this counseling process?

_____
_____
_____
_____
_____
_____
_____

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DISCLOSURE STATEMENT

Welcome to ColWen Counseling Services, PLLC. I am pleased to work with you toward achieving your mental wellness goals. This document provides information regarding my professional services and business policies. I will discuss any questions you may have about this information or any other matters at the beginning of our work together.

Qualifications

I am a Licensed Clinical Mental Health Counselor (LCMHC #7001) in the state of North Carolina. I earned a Bachelor's Degree in Sociology (1997) and a Master's Degree in Clinical Psychology (2003) from Fairleigh Dickinson University in Madison, NJ.

I have been working in the mental health field for 20 years, specifically providing therapeutic and consultation services to adults and adolescents dealing with depression, anxiety, substance abuse and trauma. For 10 years, I have worked with two organizations that provide Employee Assistance Program (EAP) services to clients. I provided consultation services on a variety of clinical issues.

Mental Health Services

At ColWen Counseling Services, PLLC I provide individual private therapy to adolescents and adults (age 14+) dealing with:

Depression and Mood Disorders	Identity Issues
Anxiety Disorders	Trauma & PTSD
OCD	Life Transitions and Adjustments
Social Anxiety	Grief and Bereavement
Relationship Issues	Aging Parents
LGBT Issues	Workplace Issues
Lifestyle and Stress Management	Parents Dealing with Adolescent Challenges
Communication Challenges	College Transition

I work with all people regardless of race, age, national origin, gender, marital status, disability, religious or political affiliation or sexual orientation.

Therapeutic Approach and The Counseling Process

The counseling process is based on honesty and collaboration. Each person is unique and has their own experiences and expectations. It is my intention that we will work together in a safe, comfortable, and respectful environment to accomplish and address what it is that is important to you.

I work mostly with Cognitive Behavioral techniques, but I draw from a variety of theoretical orientations and will always be focused on working with your individual needs. In the counseling process I will do my best to help you address the issue(s) you are looking to explore. The initial consultation will focus on a general assessment of your needs and expectations. If it is determined that I am not best suited to work with your clinical issue(s), I will refer you to a provider that would be more suitable. At the completion of the initial consultation we will determine, together, the best course of action, including how often we should meet. Since the counseling process will evolve as we work together, we will periodically assess how things are progressing and determine whether modifications need to be made. Please ask me questions about the counseling process at any time during our work together.

Understanding the Counseling Relationship

I believe, that in order for change and growth to occur, a compassionate, safe and non-judgmental counseling environment must exist. As you discover your own strength and wisdom, I will recommend interventions with the purpose of facilitating progress towards your goals. I tend to focus interventions that promote emotional awareness and understanding, mindfulness, self-reflection, acceptance and committed action toward positive mental wellness.

Although there are no guarantees, counseling in of itself is a journey that can lead you to better relationships, solutions to specific problems or challenges and a reduction in feelings of distress.

The counseling relationship will remain strictly professional and will focus exclusively on your concerns. Please understand that gifts of any kind are strictly prohibited.

Confidentiality

The client has a right to confidentiality of all that is discussed in our counseling sessions. The confidentiality privilege is protected not only by my profession's code of ethics, but also by North Carolina state law.

Written permission, in the form of a release, will be required in order to disclose specific information from our counseling sessions to a third party, including your insurance company. You may revoke that permission at any time. Your insurance company may require a specific diagnosis to describe your condition in order to consider your counseling services claims and to render reimbursement through your out-of-network benefits. Diagnoses are clinical terms that may describe the nature of your issue(s) and about whether they are short-term or long-term. All diagnoses come from a book titled the DSM-5. If I do use a diagnosis, I will discuss it with you.

If you elect to communicate with me by any means of electronic communication, including email and text messaging, please be aware that information transmitted is not completely confidential. All communications are retained in the logs of your or my service provider(s) and can be attained and reviewed at any time. It is strongly recommended that electronic communication be limited to general inquiries or scheduling changes.

Information shared during our counseling sessions will be kept confidential. However, there are some situations where a breach of confidentiality may be required. They are:

(1) If it is determined that you are in danger of harming yourself or another person.

(2) If I have reason to suspect that a child, an elderly person or disabled person is being abused or neglected, I am legally required to file a report with the appropriate state agency.

(3) If there are legal proceedings which I am court ordered to disclose information regarding your treatment.

(4) In situations of a medical emergency.

(5) If you initiate a complaint or litigation against me

We can discuss any questions about confidentiality that you may have at any point prior to or during our work together.

Record Keeping

My client records are very basic and include that you have attended our counseling session, what topics and interventions we have discussed. If you prefer that I keep no records, you must provide me with a written request to this effect for your file and I will only note that you attended therapy in the record. You have the right to request a copy of your file at any time. You have the right to request that a copy of your file be made available to your health care provider with written release and permission. My client records are maintained in a secure location.

Professional Fees

Counseling sessions will typically be 50 minutes in length. All sessions, including the initial consultation, will be $95. During the initial session we will discuss your goals and develop a plan, including frequency of sessions. This fee is due at the conclusion of each session and may be paid with cash or by making a check payable to ColWen Counseling Services, PLLC. $25 will be charged for returned checks. Payment plans are available and will be arranged during the initial session if requested by the client.

Insurance Policy

If I am in-network with your insurance plan, I will submit claims. You are responsible for any co-pay, so-insurance, and/or fees not covered by your insurance at each counseling session.

If I am out-of-network provider with your insurance plan, you are responsible for the full fee at each counseling session. Upon request, I will provide you with a receipt that you can file with your insurance company to request reimbursement. You are encouraged to consult with your insurance company to understand your out-of-network coverage and eligibility for reimbursement of counseling services. You may also be able to use a Health Savings/Flex account to cover the costs.

Flexible Appointments

I am available to make appointments that are flexible and convenient with your schedule, including early mornings starting at 7:30am, evenings up to 8pm, and Saturdays or Sundays. Please contact me at 919-424-1937 to discuss what works best for you and to schedule your appointment(s).

I am not available to answer the phone when with a client. You may leave a voicemail message and I will return your call within 24 hours, with the exception of weekends and holidays.

No Show/Cancellation Policy

Out of courtesy for my schedule and that of all of my clients, if you are unable to keep an appointment, please call to cancel and reschedule within 24 hours of your scheduled session. With the exception of illness or an emergency, if a cancellation is made with less than 24 hours notice or you do not show for your appointment, there will be a charge of $45. If you are late for a session, we will still end the session on time and you will be billed for the full session.

Repeated no shows or late cancellations may result in discontinuation of counseling services.

In Case of Emergency

I do not provide emergency services, however, I will do everything possible to see you as soon as possible in the event an urgent situation should occur. If you are experiencing a crisis that you feel needs immediate support, please call your primary care physician, go to the nearest hospital emergency room or call 911.

Social Media

I do not accept friend or contact requests from any clients on any social networking platforms. I believe that these social media connections with clients can compromise your confidentiality and our privacy and can also compromise the boundaries of the counseling relationship.

Complaint Procedures

If you are dissatisfied with any aspect of the counseling process, please discuss with me so that we can work together to find a more efficient and effective way or determine whether referral to another provider would be appropriate. If you believe that you have been treated unethically and have not found satisfaction in trying to resolve the issue with me, you may contact:

North Carolina Board of Licensed Clinical Mental Health Counselors

P.O Box 77819 | Greensboro, NC 27417 | 844-622-3572

Acceptance of Terms

You are encouraged to discuss any questions or concerns you have about entering the counseling process that I have outlined. Please sign below indicating that you have read and understand the information provided above and voluntarily agree to participate in counseling services.

Client Name (Printed): _____Date:_____

Client Signature: _____ Date: _____

Guardian/Parent Signature:_____ Date:_____

Clinician Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

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

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.

2. Payment: I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Health Care Operations: I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by me and will not otherwise be used or disclosed without your written authorization.

2. Marketing Communications: I will not use your health information for marketing communications.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.

C. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

D. Right to Request Amendment: You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

E. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request at any time.

F. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact me at 919-424-1937. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective March 17, 2018.

B. Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in my office and on my website.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form, when completed by you, acknowledges that you have received a copy of the Notice of Privacy Practices for Gregory R. Fox, LCMHC, ColWen Counseling Services, PLLC.

I,_____, acknowledge that I have received a copy of the Notice of Privacy Practices for Gregory R. Fox, LCMHC, ColWen Counseling Services, PLLC.

Client Signature: _____ Date: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify): _____

This form will be retained in your client records.