

Christian Counseling and Coaching Associates of Raleigh

INTAKE INFORMATION

This form will be retained in your confidential record.

Please complete this section ONLY:

Today's Date: _____ Referral Source: _____

Name: First Person _____ Occupation: _____

(Second Person) _____ Last _____ First _____ MI _____
Occupation: _____
Last _____ First _____ MI _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

E-mail: His _____ Hers: _____

Phone: Home/Work: _____ Cell: His: _____ Hers: _____

Date of Birth: His: ____ / ____ / ____ Hers: ____ / ____ / ____

Marital Status: Single Married (____ years) Separated Divorced Cohabitation Widowed
(First Marriage Second Marriage Third Marriage)

Children: Names/Age _____

Ethnic Group: White Black Hispanic Asian Native American Other _____

Questions:

1. What are the primary issues that you want to address in counseling or coaching today?

1.

2.

3.

2. Are you presently using medications prescribed for mental/emotional issues? Please explain:

3. May we have a credit card to keep on confidential file for future charges:

Card # _____ Exp: _____ Code: _____ Zip Code: _____

REMINDER: Please call or text to cancel or reschedule at least 24 hours in advance. If we do not receive this notice, a \$75 charge will be processed for the missed session and full fee for any future missed sessions.

For Office Use Only:

Remarks:

DSM V:

Therapist/Coach Signature:

Date:

CHRISTIAN COUNSELING AND COACHING ASSOCIATES OF RALEIGH

ANGEL H. KING, MCLC

**7008 Harps Mill Road, Suite 103
Raleigh, NC 27615**

**(919) 260-5830
E-mail: angel@ccaraleigh.com**

My Qualifications

I am happy you have chosen me to be your Life Coach. Here is some information relevant to my coaching qualifications. In addition to my master certification in Life Coaching, I am certified through Cornell University in Plant-Based Nutrition and credentialed in Radiology. I enjoyed dual careers in medicine and ministry for many years before joining the CCA team.

Certification

I received my master's credentials through the Board of Christian Life Coaching (BCLC), an affiliate of the American Association of Christian Counselors (AACC). I am also pursuing my certification as a Biblical Counselor through Light University. My MCLC certification number is #0231.

Coaching Background

I have many years of experience of (unstructured) coaching, as well as ministry and medical management experience. Past clients I worked with were those who desired assistance with goal setting, team building, overcoming organizational challenges, patient advocacy, grief and loss, and those who desired to set goals of personal and spiritual growth.

Current clients I work with, in general, are dealing with life transitions or adjustments and seek coaching to navigate difficulties as they set goals for their future. I do not accept clients who, in my professional opinion, are not committed to process of coaching and cannot be helped using the techniques I offer. I specialize in life balance, stress and time management, organizational, grief, and crisis care coaching.

Session Fees and Length of Service

My fee is \$110 for a 50-minute session. It is often necessary for calls throughout the coaching process. Please be aware if a call exceeds 15 minutes a partial session fee may be applicable. Fees may be paid with cash, check or credit card. Payment should generally be made at the beginning of every session in my office. I provide my clients with a receipt that shows verification of payment and may be used in seeking potential reimbursement of fees paid (HSA or FSA account holders).

Commitment

My commitment to you is that each session will be met with encouragement, supported by hope, addressed with compassion and balanced with accountability for the goals you set. I ask that you fully commit to the process of coaching and be ready to receive all that God offers to you as you seek His plan and direction for this part of your life.

Missed Appointments

As part of the coaching process, “homework” or next steps will be given. If are met with challenges to complete these assignments between sessions, please keep your next appointment anyway.

If you are unable to keep an appointment, please call to cancel or reschedule at least 48 hours in advance. If we do not receive such advance notice, you will be responsible for paying \$75 for the first missed session and full fee for any future missed session. We may also request pre-payment for the next session scheduled.

Confidentiality

I will keep confidential anything said in sessions as part of the coaching relationship, with the following exceptions: (a) I am directed in writing by my client to disclose information to someone else, (b) it is determined a client is a danger to himself or herself (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Christian Counseling Associates of Raleigh, PLLC

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to us. We will maintain the privacy of your health information and we will not disclose your information to others unless you tell us to do so.

A federal law commonly known as HIPAA requires that we take additional steps to keep you informed about how we may use information that is gathered in order to provide health care services to you. As part of this process, we are required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights.

If you have any questions about this Notice please contact our Privacy Officer at (919) 737-1874.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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).

For more information about my privacy practices, or for additional copies of this Notice, please contact us using the information listed in Section II G of this notice.

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 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 by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician 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 without your written authorization.
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 Alternative Communications.** You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
- C. **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.
- D. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or healthcare operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.
- E. **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.
- F. **Right to Obtain Notice.** You have the right to obtain a paper copy of this notice by submitting a request to the Privacy Officer at any time.
- G. **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 the Privacy Officer at (919) 737-1874. 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 on April 14, 2003.
- B. **Changes to this Notice.** I may change the terms of this Notice at any time. If I change the 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 the waiting area of my office. You may also obtain any revised Notice by contacting the Privacy Officer.

Christian Counseling and Coaching Associates of Raleigh

Dr. Mike Garrett Ph.D., LCMHC · Rhonda Garrett M.A., LCMHCA
Ginna Bustle M.S.W., LCSW · Rick McKoy M.A., LCMHCA
Angel King, BCMLC · Dr. Russ Rainey Ph.D, BCC

Consent for Professional Services

Client Name: _____ **Date:** _____

Receipt of Notices and Request for Services (Please initial):

- I accept the Professional Disclosure statement for my provider (included or from website).
- I accept the HIPAA Notice of Privacy Practices (included or from website).
- I understand this consent allows me to utilize these professional services in the office, by video, or by phone. I acknowledge the option of telehealth appointments and consent to the benefits and accept liabilities. I understand and agree to take appropriate caution for privacy when utilizing any telehealth services.
- I understand if I stop making appointments that my case will be closed 90 days after my last appointment.
- I give permission for voicemail, text, and/or email reminders about my appointments.
- I have read and acknowledge if I cancel an appointment with *less than 24 hours notice* I will be charged a \$75 late fee for the first appointment and full fee for any future late cancellations or no show appointments.
- I hereby unconditionally guarantee payment to Christian Counseling and Coaching Associates of Raleigh for all costs, charges and expenses incurred.
- I hereby request counseling and/or coaching professional services.

Client's Signature _____ **Date** _____

Counselor or Coach's Signature _____ **Date** _____