Inner Pathways Counseling Service

CLIENT INTAKE FORM

Today's Date: _____

CLIENT INFORMATION

*Client's Name	❑ Mr. ❑ Ms.	*Marital Status (Circle One) Single / Married / Other

Date of Birth / /	Address:	Gender ❑ M ❑ F

Client currently receiving psychological Services at another agency?? Yes No	Mobil Number: ( )
Any Upcoming court cases? Yes No	Home/Other: ( )

How did you hear about our services? ❑ Family ❑ Friend ❑ Facebook ❑ Other	Referred: _____

INSURANCE INFORMATION

*Person Responsible for Bill	Date of Birth / /	Address (if different)	Phone No. ( )

***Please Select Your Primary Insurance Provider**	❑ Tricare Prime (Active) ❑ Tricare Standard (Active) ❑ BCBS _____ ❑ Tricare Prime (Retired) ❑ Tricare Standard (Retired) ❑ Medicaid ❑ TriCare for Life ❑ Medicare ❑ Self Pay (Cash) ❑ Other _____

Sponsor Name	* S.S.N. or Ins. Card #	Date of Birth	Group:	Co-Payment $

Client's Relationship to Sponsor ❑ Self ❑ Spouse ❑ Child ❑Other _____			
Name of Secondary Insured's Name		Group #	Policy #

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Client	Phone No.

Please Provide Identification and Insurance Plan

PLEASE READ THE FOLLOWING CAREFULLY

X_____ (Initials) I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Inner Pathways Counseling Service will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X_____ (Initials) I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time without threat of termination. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X_____ (Initials) I acknowledge that I have received and read a copy of the HIPAA Information Notice of Privacy Practices. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all HIPAA that we maintain. We will provide you with a revised notice by distributing to you in the office or sent to you via email.

X_____ (Initials) I acknowledge and give permission that in case of medical emergency or crisis, I authorized Inner Pathway LLC staff and/or my clinician to call 911 and share information about my condition.

X_____ (Initials) I acknowledge that I have read and understand the copy of the Financial Policy. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all HPIAA that we maintain. We will provide you with a revised notice by distributing to you in the office.

X_____ (Initials) I hereby authorize the release of necessary medical information for insurance reimbursement purposes. I authorize the payment of medical benefits to the provider of services.

X_____ (Initials) I understand that insurance panels require communication of my treatment process with my primary care manager.

X_____ (Initials) I have read and understand the Professional Disclosure Statement.

X _____ (Initials) Communication: E-mail is not a suitable forum for communication of emergencies or crisis situations. By e-mailing/Phone Text you have the understanding that e-mail communication carries risks to confidentiality.

Yes _____ No _____ (Initials) I consent for the presence of Therapy Dog during my child/self therapy session.

_____ _____

Child (ONLY IF APPLICABLE) Date of Birth

_____ _____

Print Parent/Guardian Name Relationship to Child

_____ _____

Signature Date

Maria D. Marquez, MA, LMFT

Professional Disclosure

Credentials and Experience

I earned my Masters of Arts degree in Counseling from Webster University in 2012. I received my bachelor's degree in psychology in 2003. I am licensed in North Carolina as Marriage and Family Therapist (#1579). I have experience working with families and children with behavioral problems and family relations.

Description of Clientele

I provide child, adolescent, family, couples, individual, and group counseling and periodically facilitate psycho educational groups on various topics. I have experience working with individuals with anger management, assertiveness, parenting, stress management, trauma victims, and self-esteem issues.

Description of Services

I operate from a philosophy that emphasizes meaning in one's life, responsibility, and the ability to express oneself in your own unique way. I believe that counseling should be tailored to the unique individual or couple, my approach is cognitive-behavioral that emphasizes changes in behavior and thinking. It is expected that some uneasiness or painful emotions may occur during therapy. Your participation in therapy is essential toward helping you address your concerns. All sessions will be conducted face to face by appointment only. Telephone sessions or email consultation is not permitted. If special reports or evaluation is requested a seven business day is required. You may choose to terminate therapy at any time during the course of treatment; however, I reserve the right to encourage you to continue in therapy if I find it beneficial for your growth and development. I do ask that you take responsibility for homework that may be assigned from time to time.

Professional Fees

Fees charged per session for counseling services are as follows:

Intake session	$195
One 55 minute session	$ 125
Group counseling session	$ 30
In between consultation fee per minute	$ 1

Other services include report writing, telephone conversations, consulting with other professionals (at your request), and time spent performing any other advocate services you request of me. I prorate the charge for these services based on the hourly rate of **$85.** These charges are not billable to an insurance company and will be due prior to the next appointment.

If you become involved in legal proceedings that require my participation, you will pay for all of my professional time, including preparation and transportation costs even if I receive a call to testify by another party. Because of the difficulty of legal involvement, I charge **$195** per hour for preparations and attendance at any legal proceeding.

Fees are collected at the beginning time of the session. Payment is accepted in cash, Visa, Master Card, American Express, and Apple Pay.
In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, a monthly service charge of **2%** will be assessed against any outstanding balance. I have the option of using legal means to secure the payment on past due accounts. This may require me to disclose otherwise confidential information.
Once a session is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of

cancellation. ***Company policy allows for a $75.00 no show or late cancellation fee.***

Confidentiality

All information shared will be kept *confidential* with the following *exceptions*;

a) If I believe you are a *danger* to yourself or someone else
b) If you give me *written permission* to disclose information
c) In the case of *abuse* to a child or an elderly person confidentiality will be waived
d) If the information is court ordered
e) If you desire to seek reimbursement from a managed care company, the disclosure of confidential information may be required for reimbursement
f) In case of a *Medical Emergency, I am authorized to call 911 and share needed information for treatment.*
g) These rights are waived if accusations of misconduct are brought.

Even under these circumstances only essential information will be revealed and as much as possible you will be informed before information is disclosed. In the event the client is a minor, parents or legal guardians may be included in the counseling process as is appropriate, however measures will be taken to safeguard confidentiality, always acting in the best interest of the client. As a counselor I may be receiving supervision (by an individual who is bound by the same code of ethics as I am) to continually improve my counseling skills, any information shared during supervision will be discussed for professional purposes only and every effort will be made to protect the client's identity. Clinical diagnosis is part of the counseling process. All clinical diagnosis, clinical reports, and records become part of the confidential clinical file. I reserve the right to participate in third party phone calls, court appearances and email correspondence.

Complaints

If, at any time, you feel my behavior or my counseling approach is inappropriate or troubling to you, please let me know. If, however, you do not feel your concerns are being addressed appropriately, feel free to contact the following:

Mrs. Amber Seneres
Administrator

Inner Pathways LLC.
351 Wagoner Dr. Suite 324
Fayetteville, NC 28394
gottherapync@gmail.com
(252) 619-5451

NC MFT Licensure Board
201 Shannon Oaks Circle,
Suite 200 Cary, NC 27511
www.nclmft.org
(919) 654-6914

Acceptance of Terms

We agree to these terms and will abide by these guidelines.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Counselor's Signature Date

Inner Pathways Counseling Service

I, _____ authorize Inner Pathways Counseling Center to charge $50.00 no show fee on the credit card listed below. My card will be charged within 24 hours of my missed appointment. I understand that refunds are not possible for visits that have been completed. If my insurance company issues checks to me for visits with Inner Pathways Therapy, I will sign them over to Inner Pathways Counseling Center and bring them to my therapist within 2 weeks from the date of issue, or my card may be charged for the amount of the check.

If I need to cancel an appointment**, **I will provide 24 hour notice and 72 hours for weekend or Monday appointments. (if your appointment is at 10:00 AM on Tuesday you must cancel before 10:00 AM on Monday

This authorization will remain in effect until I notify (therapist's name) that I do not want future charges to be authorized.

Please write legibly. Please double check the numbers you've written to ensure correct information is given.

Credit Card Information		
Credit Card Number		
Expiration Date		CVC Code
Name of Card Holder	Address	City, State and Zip
Email address		
Would you like your receipt text to you?	*Yes*	*No*

Recurring deductibles can also be charged to this Credit Card:

_____Yes _____ No
(Initials)

_____ _____
Card Member Signature Date

Inner Pathways Counseling Service

351 Wagoner Dr. Suite 350
Fayetteville, NC 28303
Phone: (910) 644-4584 ~ InnerPathwaysNC@gmail.com ~ Fax: (910) 401-2171

Two Way Consent for Exchange of Information:

Maria D. Marquez, MA, LMFT _____

351 Wagoner Dr. Suite 324 _____

Fayetteville, NC 28303 _____

Requesting the following information: _x_Behavioral Plan __Disability Determination __Discharge Planning & Coordination of Care __General Information __HIV/AIDS/Communicable/Non-communicable Disease __Insurance Information __Legal Records _x_ Medication Records _x_Progress Notes _x_Psychiatric/Psychological Assessment, Testing, Reports _x_Referral & Appointment Date(s) __School Records __ Substance Abuse Information

I, (Name)_____ hereby authorize the release of confidential information concerning (Name)_____ (DOB)_____.

(Child Name if Applicable)

_____(Initials) 1. Reason for referral

_____(Initials) 2. Information including social or medical (HIV/AIDS NC General Statute 130A – 143) affecting aforementioned client's current functioning

_____(Initials) 3. Information including psychological/psychiatric, social, or Substance Abuse (42 CFR Part 2) affecting client's current functioning

_____(Initials) 4. Psychological/psychiatric evaluation results

_____(Initials) 5. Current medications prescribed

_____(Initials) 6. School academic achievement, grade level, and behavior

_____(Initials) 7. Other_____

I understand that the information exchanged will only be used for educational and therapeutic collaborative purposes. I allow for the exchange of information to be done via paper, oral, and/or electronic correspondence. I also understand that I may withdraw this consent at any time, thereby prohibiting any future exchange of information to the extent that the action has not already been taken. This consent will expire automatically **one year** from the date on which it is signed.

This authorization and request is fully understood and is made voluntarily on my part.

Signed: _____Date: _____

(Circle: Patient, Guardian, Parent)