Carlisle Counseling & Consulting Services

Instructions for your first appointment

Welcome to Carlisle Counseling & Consulting Services! Attached is your Registration packet (**Adult Registration Packet**) that must be completed **prior** to your first appointment with us. You can also access your packet on our website at https://www.carlisleforgrowth.com/forms.

Please complete your Registration Packet, add a legible copy of your **Driver's License** and **Insurance Card** and return it to us before you first session. Below is a checklist to help you determine if you have all items needed before sending it to us. Please do not forget to Sign your forms before sending.

Registration Packet Checklist:

_____ Patient Registration Forms (15 pages)

_____ HIPAA Notice of Privacy Practices (4 pages) (Do not need to return. This is for your files)

_____ Mental Health Intake Forms (7 pages)

_____ Copy of Driver's License

_____ Copy of Insurance Card ***Have you met your Deductible? _____ What is your Co-Pay? _____**

_____ Your preferred method of Payment

___ Cash ___ Debit/Credit ___ CashApp ($CARLISLE80) ___ Vemno (@Shalonda-Carlisle) ___ PayPal

___ Invoice (provide email) _____ (provide phone)_____

Please Fax your completed Registration Packet to **601-202-1798** or email it to Carlisle Counseling & Consulting Services' (carlisleforgrowth@yahoo.com) or your provider.

You can also bring completed Registration Packet Checklist with you to your first session. If you choose to do this, you **MUST** arrive at least 15 minutes prior to your scheduled appointment.

Payment for Service

Payment is due at the time of service. Please be prepared to submit payment for your session upon arrival. This includes your Copay/Cost Share if you are using insurance. If paying with Cash, please have the exact amount. We do not keep cash in the office, so we will not be able to provide change.

If you are using insurance, contact your insurance to verify the following:

- Is Carlisle Counseling & Consultant Services/Dr. Sholanda Carlisle is a supported provider?
- Have you met your deductible? (if applicable)
- What is your Co-Pay for Behavior Health/Mental Health Services?

We accept all major Credit/Debit Cards, PayPal (carlisleforgrowth@yahoo.com), CashApp ($CARLISLE80) and Vemno. You also have the option to be invoiced prior to your sessions. Just provide the email you want your invoice to go to. Telehealth/virtual sessions **must** be paid at least 24 hours prior to your scheduled session.

We accept all forms of Medicaid, Chips, Ambetter, BlueCross BlueShield, United HealthCare and Cigna. Sorry, we do not currently accept Medicare or Tricare. This list is subject to change without notice, therefore please check back for updates or contact us at 601-559-0599 or 769-300-1681.

Carlisle
COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

Registration Form

Contact Information:

Last Name: _____ First Name:_____ MI:_____
Preferred Name:_____
DOB:_____ SSN#_____
Street Address:_____
City/State/Zip:_____

Communication:
Phone Home: _____ Cell:_____
Is it OK to leave messages regarding appointments, results, etc. on the above numbers? Y N

Email address: _____
Is it OK to send messages about your appointments, results, etc via email? Y N

Emergency Contact:
Who should be contacted in case of an emergency?

Name: _____
Relationship:_____
PhoneHome:_____Work:_____Cell:_____
Address:_____

Insurance Information:

Name of Primary Insurance Company: _____

ID/Policy #: _____Group#_____

Who is the subscriber? Please check: Self _____Parent_____Spouse_____

Subscriber's Full Name:_____

Subscriber's DOB_____

Subscriber's Employer: _____

Carlisle
COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

Consent For Treatment

I have chosen to receive mental health services in the form of counseling/therapy for myself and/or my child Carlisle Counseling & Consulting Services. My decision is voluntary, and I understand that I may terminate these services at any time unless my participation has been mandated by a court of law.

Nature of Mental Health Services
I understand that during the course of treatment I may need to discuss material of any upsetting nature to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with Treatment Plan
I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Supervision
I understand there are certain circumstances which may require Carlisle Counseling & Consulting Services provider (s) to receive supervision. These circumstances include, but are not limited to the following:

- State licensure regulations may require our therapists or service providers to receive ongoing supervision.
- Accreditation organizations, as well as insurance companies, may require our treatment plans to be reviewed.
- The standards of care which guide most mental health professionals recommend that supervision and/or consultation be obtained in high-risk situations such as threats and/or acts of harm to self or others.

COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

Client Rights

- The right to be treated with dignity and respect by all staff
- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any
- time about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be videotaped, audio recorded, or photographed

Emergencies
I understand I may reach my service provider directly or Shalonda Carlisle at 601-559-0599. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency, I may call 911 or go to the nearest emergency room for evaluation and treatment.

Patients must give voluntary consent for mental health treatment. Your signature (or that of your legal guardian) will demonstrate consent for receiving mental health treatment from the Carlisle Counseling & Consulting Services. I voluntarily consent to mental health treatment as performed by the Carlisle Counseling & Consulting Services and its staff. This treatment may include but not limited to: assessment, screening, consultation and recommendations, psychotherapy, holistic services and psychiatric medication management. I understand that mental health treatment may involve certain risks and benefits and I understand these risks and benefits. I also understand the risks and benefits of declining treatment. I am also aware that I have the right to request information about alternative treatment options, should they exist. I have read the above information and I authorize the Carlisle Counseling & Consulting Services to provide mental health services to myself or this patient (if guardian).

I have read, discussed and understood all of the above.

_____

Signature/ Date

COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

Financial Policy Agreement

Consent to File Insurance
Payment for services provided by the Carlisle Counseling & Consulting Services is due at the time that services are rendered. If the client is covered under insurance, payment of any applicable copayment, co-insurance, or deductible is due at the time of service. If Carlisle Counseling & Consulting Services is not contracted with the insurance, payment for services is due in full at the time that services are rendered.

As the patient/guarantor, you are financially responsible for any fees and costs associated with all services you receive from our office.

As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. You are strongly encouraged to verify your benefits and coverage to ensure you fully understand what is covered. If your specific insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

You agree that it is your responsibility to inform the practice of any changes to insurance plan prior to each of your visits, or you may be responsible for the full fee. Some services may not be covered by health insurance. You agree to be fully responsible for payment for all services that are not covered by your health plan. This may include charges for telephone consultations, written correspondence, or reports in connection with a client's evaluation or treatment, including consultation or correspondence with the client, family members, past or current treatment providers, educational professionals, attorneys, courts, agencies, or others. If these charges are excluded from your coverage by your health plan, they will be your responsibility. There will be a charge of $40.00, including applicable fees from the financial institution(s) for returned checks or disputed credit card payments. All patients are required to have a credit card on file to initiate or continue care. It is your responsibility to update any expired cards. All outstanding balances are expected to be paid within 60 days. Payment plans can be provided upon request.

Fees Not Billed to Insurance/Professional Services

Carlisle Counseling & Consulting Services may provide, on a case-by-case basis consultations with family members, past or current medical providers, educational professionals, attorneys, courts, agencies or others. Limited telephone consultation is part of routine patient care and is undertaken without charge. However, when extensive or other than routine telephone consultations, written correspondence or reports are requested or required, a charge for these services will be applied. To comply with federal laws including HIPAA, this office must have a signed authorization from the patient, or responsible party stating who we are authorized to release information to. You can contact our office or visit our website for a copy of the form. If these charges are excluded from your coverage by the health plan, they will be your responsibility.

Requesting Records from Carlisle Counseling & Consulting Services for self/provider/ other entities

To request records from the Carlisle Counseling & Consulting Services for yourself, another provider or entity we require that you complete the "Authorization to Release Medical Records from Carlisle Counseling & Consulting Services" form in entirety. Incomplete forms will not be processed and will delay your request. The cost is a $15.00 minimum processing fee and 25 cents per page to fax or copy your record and additional cost for required certified mail (postage and handling included in invoice paid prior to receipt). We do NOT email records. Processing is 8-10 business days for most circumstances. Please be aware, although you may have signed a release for communication, if you are requesting that we send records, you will need to complete the above process each time you request records to yourself or to be sent to any provider or entity, which includes primary care or change of psychiatric provider upon termination.

Patient/Guardian Responsibility

I understand and agree that I am financially responsible for all charges for all services rendered by Carlisle Counseling & Consulting Services for myself and/or my child.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any co-pays or unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office o f any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare or Medicaid patient, I understand that I need to provide the office both my Medicare or Medicaid ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent.

Appointment Cancellation, No-Show, and Late Arrival Policy
Carlisle Counseling & Consulting Services' policy requires patients to cancel 1 day (24 hours) in advance of their appointment to avoid a cancellation fee. Clients are expected to arrive on time for their scheduled appointments out of courtesy to the other clients and providers/clinicians. Clients who arrive more than 15 minutes late for an appointment may not be seen and will be charged a late cancellation fee. Carlisle Counseling & Consulting Services charges a $40.00 fee for all late cancellations, no-shows, or late arrivals.

If you miss two appointments without prior cancellation (24 hours when possible, or prior to appointment time on the same day in emergency situation), you will be required to pay a $40.00 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time. When the appointment is kept, this $40 fee will be applied to your office visit fees or refunded as appropriate. If the appointment is missed without proper notice of cancellation, the deposit becomes non-refundable.

COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

Carlisle Counseling & Consulting Services makes every attempt to remain on time for appointments, however, occasionally circumstances arise that may result in an appointment delay. For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee

How to **Cancel Your Appointment**
If you need to cancel your appointment, please call your provider or our office **at 601-559-0599** between the hours of 4:30 pm and 8:00 pm. If necessary, you may leave a detailed voicemail or text message. We will return your- call as soon as possible.

Discharge Policy
At the discretion of Carlisle Counseling & Consulting Services, a client may be discharged from the Practice and their insurance notified if any of the following guidelines are not followed:

- Patient's failure to follow the recommended treatment plan or medical instructions including the Controlled Substance Agreement, if applicable.
- Patient fails to meet financial responsibilities.
- The provider cannot provide the level of care necessary to meet the patient's needs.
- The member and/or member's family is abusive to the provider and/or staff.
- The patient or provider moves out of the service area.

Confidentiality
Confidentiality is a basis of mental health treatment and is protected by the law. Aside from emergency situations, information can only be released about your care with your written permission. A release is not needed for providers of Carlisle Counseling & Consulting Services to consult with other providers within the Practice. If insurance reimbursement is pursued, insurance companies also often require information about diagnosis, treatment, and other important information in the Disclosure of Health Information as a condition of your insurance coverage. Several exceptions to confidentiality do exist that require disclosure by law:

(1) danger to self – if there is threat to harm yourself, we are required to seek hospitalization for the client, or to contact family members or others who can help provide protection;

(2) danger to others – if there is threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization;

(3) grave disability or impairment – if due to mental illness, you are unable to meet your basic needs, such as clothing, food/water, medical care, and shelter, we may have to disclose information in order to access services to provide for your basic needs;

(4) suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency;

(5) certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require testimony through a court order. Although these situations can be rare, we will make every effort to discuss the proceedings accordingly.

(6) in the event of a national emergency such as a global pandemic, terrorism, wartime or any other catastrophic event, Carlisle Counseling & Consulting Services will follow the Governor's Orders of each state of the patients' residence to ensure continuation of health care for reasonable amount of time.

* We also reserve the right to consult with other professionals when appropriate. In these circumstances, your identity will not be revealed, and only important clinical information will be discussed. Please note that such consultants are also legally bound to keep this information confidential.

Contacting Your Provider

Providers are not immediately available by office telephone, please call your provider directly or via the office at 601-559-0599. Calls are generally returned within 2 business days. Always leave a phone number where you can be reached along with any updated contact information. As we are an outpatient practice, we do not service walk ins or provide crisis services. If your call is an emergency, please call 911 immediately instead of calling the office. Emergency mental health services are provided by all hospitals through their emergency rooms and do not require appointments. Emergency room physicians can contact your provider at any time so please provide them with their contact information. When your provider is unavailable for extended periods of time (i.e., vacation, conferences, etc.), a

trusted colleague will provide coverage, if deemed necessary. Please also note that email should never be used for urgent or emergency issues.

Appointment Confirmations
Carlisle Counseling & Consulting Services will attempt to confirm appointments via email and text upon your consent, however, it is your responsibility to know the date, time and location of your appointment. Carlisle Counseling & Consulting Services has no control in regard to your phone or email connection or reliability. Inability or failure to receive a reminder or appointment confirmation via text or email is not a reason for waiver of fees.

Communication for Appointment Reminders
Carlisle Counseling & Consulting Services may need to use your name, phone number, email address ("Contact Information") to contact you with appointment reminders via phone, text or email. If this communication is made by text, a text message will be left on your phone. You have the right to refuse to give Carlisle Counseling & Consulting Services your consent to use your telephone number and/or email address for appointment reminders. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. Should you agree to communicate via email, telephone or any electronic method of communication, Carlisle Counseling & Consulting Services cannot guarantee that those communications will remain confidential. There is a risk that the electronic or telephone communications may be compromised. There is never a 100% guarantee that information will remain confidential when transmitted electronically.

Legal
Legal matters requiring the testimony of a mental health professional can arise. This, however, can be damaging to the relationship between a patient and their provider. As such, we generally recommend that you hire an independent forensic mental health professional for such services. Please review our Fees for Court Appearance Policy.

Recording Sessions
Patients are not allowed to record sessions or providers/clinicians under any circumstances.

Controlled Substances
At Carlisle Counseling & Consulting Services, we do not prescribe controlled substances.

Our medication providers will not treat patients who are prescribed controlled substances from another provider. All patients are subject to urine drug testing per discretion of medical provider.

Inclement Weather

The Carlisle Counseling & Consulting Services closes for inclement weather per the discretion of the Practice and will offer telehealth sessions if able to given weather circumstances. If the Practice closes for inclement weather, it will be posted on the website. Patients are instructed check the website for updates and will be contacted via phone if their appointment requires rescheduling

COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

Telebehavioral Health Treatment Consent

What is Telebehavioral Health?
"Telebehavioral health" means, in short, services delivered via telebehavioral health rely on a number of electronic, often Internet-based, technology tools. These tools can include video conferencing software, email, text messaging, virtual environments, specialized mobile health ("mHealth") apps, and others.

Your Telebehavioral Health Environment:
You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions with your provider during the session. If you are unsure of how to do this, please ask your provider for assistance.

Client Understanding
I understand that Telebehavioral health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the Telebehavioral health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to Telebehavioral health, and that no information obtained in the use of Telebehavioral health that identifies me will be disclosed to other entities without my consent.

I understand that Telebehavioral health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based ommunication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

Carlisle
COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

I understand that I or my therapist may discontinue the Telebehavioral sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a Telebehavioral health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to Telebehavioral health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what Telebehavioral health platform to use and she will establish a video conference session.

Client Consent

Client Name: _____

I hereby give my informed consent for the use of Telebehavioral health in my care.

Email: _____ **Phone Number:** _____

Client Signature: _____

COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

FEES FOR COURT APPEARANCE

Fees for Court Preparation and Appearance

Please note that my fee to appear in court is $1,500 (one thousand-five hundred dollars), per appearance. In the event that I receive a subpoena to appear in court to testify on the behalf of you, your child, or any other family member, there will be a fee of
$1,500. I do not voluntarily testify in court cases. Other fees include $225 per hour to prepare records for submission to court, $225 per hour for depositions and phone contacts, and all attorney costs incurred by therapist as result of legal action.

Note that this fee is payable 7 days prior to your court date. Since I will be required to clear my calendar of all appointments and prior engagements so that I may be available to appear in court, this fee is non-refundable. If your court date is postponed and I must again clear my calendar to attend court, you will again be charged the full fee. If your court date is cancelled this fee is non-refundable.

No further appointments will be scheduled until this fee is paid in full. If this payment is not paid in full within one calendar month it will be brought to collections.

Divorce/Custody Cases

Please be advised that, if I receive a subpoena to testify in a divorce/custody case, I will not make a custody recommendation, or a recommendation of where a child should live, nor will I make a determination as to one's fitness as a parent.

Confidentiality

Your rights to privacy and confidentiality are important to me, and I work hard to protect them. There are also laws in place to protect you. Please note there are situations during court and legal proceedings where they may be compromised. Examples of this include you waiving confidentially by agreeing to disclosure the client's mental health records in a lawsuit for emotional distress; your decision to pursue a lawsuit where the client's mental or emotional condition is relevant or critical, if the client's records are

requested by a valid subpoena or court order. It is your responsibility to learn how to confidentially and privacy may be compromised as a result of legal or court proceedings.

Non-Payment

If you have not paid your court-related fees and do not respond to my attempts to contact you and work out a payment plan, I have the option of using legal means to secure the payment. This involves hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of the services provided, and the amount due. A late fee of 20% of the unpaid balance will be charged each month that a balance remains unpaid.

Clients Statement of Agreement

I have read this notice and fully understand the statement. I agree to pay the full fee of $1,500, seven (7) days in advance, for any court appearance this therapist may need to make on behalf of myself, my child, or any other family member. I understand that my therapist is not responsible for the outcome, or any judgments made, regarding my court case.

Client/Legal Guardian Signature:

_____

Client Name (Please Print):

_____

Date:

_____

Carlisle
COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

Policies & Procedures/Acknowledgment Agreement Signature Form

Acknowledgement of Receipt of Carlisle Counseling & Consulting Services' Policies

By signing this agreement, you agree that you have read, agree with and understand the Carlisle Counseling & Consulting Services' Policies which include, but not limited to, information on Carlisle Counseling & Consulting Services' consent for treatment policy, financial policy, professional fees, cancellation/no-show/late arrival, discharge policies, confidentiality, contacting your provider, confirmation and communication for appointment reminders, legal, recording sessions, controlled substances, inclement weather, telehealth treatment, fees for court appearance and you agree to abide by its terms during our professional relationship. Please look at our website to review our annually updated policy form.

Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Consent Form for Communication of Protected Health Information

I CONSENT to the communication for appointment reminders via text, email or phone. Cell phone number _____ Other contact number_____
Email Address _____

I have carefully reviewed this document. My signature indicates my full understanding and agreement of Carlisle Counseling & Consulting Services Policies & Procedures, Agreements and Consent documents.

_____ _____ _____
Please print patient's name here Signature of patient/parent/legal guardian Date

For Office Use Only: We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:
□ The patient refused to sign
□ Due to an emergency, it was not possible to obtain an acknowledgement
□ We could not communicate with the patient
□ Other (Please provide specific details): _____

Carlisle
COUNSELING & CONSULTING SERVICES, LLC
357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

HIPAA Notice of Privacy Practices

This notice describes how medical information about you/child may be used and disclosed and how you can get access to this information. Please review carefully.

You have the right to:

• Get a copy of your paper or electronic medical record
• Correct your paper or electronic medical record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we've shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated
• You have some choices in the way that we use and share information as we:
o Tell family and friends about your condition
o Provide disaster relief
o Include you in a hospital directory
o Provide mental health care
o Market our services and sell your information
o Raise funds

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. Ask us to correct your medical record
• You can ask us to correct health information about you that you think is incorrect or incomplete.
• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way or to send mail to a different address.
• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information
- We will make sure the person has this authority and can for you before we take any action

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising, we will not contact you for fundraising

We typically use or share your health information to in the following ways:

- To treat you
- To share your information with other professionals who are also treating you.
- Run our organization
- Improve your care and contact you when necessary
- Bill for your services
- Help with public health, research, and safety issues such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Comply with law
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies
- Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential

protective services
- Respond to lawsuits and legal actions
- • We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of --your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us that we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Carlisle
COUNSELING & CONSULTING SERVICES, LLC

357 Towne Centre, Suite 402
Ridgeland, MS 39157
Office : 601 -559-0599
Fax: 601-202-1798

Mental Health Intake Form

- Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name _____ Date _____

Date of Birth _____ Primary Care Physician _____

Do you give pennission for ongoing regular updates to be provided to your primary care physician? ___

Current Therapist/Counselor _____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals? _____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

- ☐ Depressed mood
- ☐ Unable to enjoy activities
- ☐ Sleep pattern disturbance
- ☐ Loss of interest
- ☐ Concentration/forgetfulness
- ☐ Change in appetite
- ☐ Excessive guilt
- ☐ Fatigue
- ☐ Decreased libido

- ☐ Racing thoughts
- ☐ Impulsivity
- ☐ Increase risky behavior
- ☐ Increased libido
- ☐ Decrease need for sleep
- ☐ Excessive energy
- ☐ Increased irritability
- ☐ Crying spells

- ☐ Excessive worry
- ☐ Anxiety attacks
- ☐ Avoidance
- ☐ Hallucinations
- ☐ Suspiciousness
- ☐ _____
- ☐ _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No.
If YES, please answer the following. If NO, please skip to the next section.
Do you currently .feel that you don't want to live? ☐ Yes ☐ No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10 (ten being strongest) how strong is your desire to kill yourself currently? ____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before?----------

Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ☐ Yes ☐ No If yes, when _____ .
Was the EKG ☐ normal ☐ abnormal or ☐ unknown?

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ☐ Yes ☐ No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ☐ Yes ☐ No
Date and place of last physical exam: _____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease	☐	☐	_____
Anemia	☐	☐	_____
Liver Disease	☐	☐	_____
Chronic Fatigue	☐	☐	_____
Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____
Asthma/respiratory problems	☐	☐	_____
Stomach or intestinal problems	☐	☐	_____
Cancer (type)	☐	☐	_____
Fibromyalgia	☐	☐	_____
Heart Disease	☐	☐	_____
Epilepsy or seizures	☐	☐	_____
Chronic Pain	☐	☐	_____
High Cholesterol	☐	☐	_____
High blood pressure	☐	☐	_____
Head trauma	☐	☐	_____
Liver problems	☐	☐	_____
Other	☐	☐	_____

Is there any additional personal or family medical history? ☐ Yes ☐ No
If yes, please explain:

_____

_____

_

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Past Psychiatric History:
Outpatient treatment ☐ Yes ☐ No
If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

Psychiatric Hospitalization ☐ Yes ☐ No
If yes, describe for what reason, when and where.

Reason	Date Hospitalized	Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

	Dates	Dosage	Response/Side-Effects
Antidepressants			
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			
Mood Stabilizers			
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol(carbamazepine)			
Topamax (topiramate)			
Other			

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			
Sedative/Hypnotics			
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			
ADHD medications			
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other			
Antianxiety medications			
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Other			

Your Exercise Level:

Do you exercise regularly? ☐ Yes ☐ No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Post-traumatic stress	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Alcohol abuse	☐ Yes	☐ No
Anger	☐ Yes	☐ No	Other substance abuse	☐ Yes	☐ No
Suicide	☐ Yes	☐ No	Violence	☐ Yes	☐ No

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

Substance Use:

Have_.You ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? ____

What is the most number of drinks you will drink in a day? ____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? ____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used dmgs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	
Cocaine	( )	( )	
Stimulants (pills)	( )	( )	
Heroin	( )	( )	
LSD or Hallucinogens	( )	( )	
Marijuana	( )	( )	
Pain killers (not as prescribed)	( )	( )	
Methadone	( )	( )	
Tranquilizer/sleeping pills	( )	( )	
Alcohol	( )	( )	
Ecstasy	( )	( )	
Other	( )	( )	

How many caffeinated beverages do you drink a day? Coffee ____ Sodas ____ Tea ____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No

Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? ____

In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Pipe. cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

What kind? _____ How often per day on average? ____ How many years? _____

Family Background and Childhood History:
Were you adopted? ☐ Yes ☐ No Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? ☐ Yes ☐ No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with? _____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____
_____

Educational History:
Highest Grade Completed? _____ Where? _____
Did you attend college? _____ Where? _____ Major? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ☐ Yes ☐ No Other type discharge _____

Relationship History and Current Family:
Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed
How long? _____
If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long? _____
Are you sexually active? ☐ Yes ☐ No
How would you identify your sexual orientation?
☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transsexual
☐ unsure/questioning ☐ asexual ☐ other ☐ prefer not to answer
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other:
_____
Have you had any prior marriages? ☐ Yes ☐ No. If so, how many? _____
How long? _____
Do you have children? ☐ Yes ☐ No If yes, list ages and gender: _____
_____
Describe your relationship with your children: _____
List everyone who currently lives with you: _____
_____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ☐ Yes ☐ No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ☐ more helpful ☐ stressful

Is there anything else that you would like us to know?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature _____ Date _____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____ Date _____

Reviewed by _____ Date _____