Carlisle Counseling & Consulting Services

Instructions for your child's first appointment

Welcome to Carlisle Counseling & Consulting Services! Attached is your Registration packet (**Child 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 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:

_____ Duplication of Service Letter (1 page)

_____ Consent for Treatment (2 pages)

_____ Consent to File Insurance (3 pages)

_____ HIPPA Authorization Form (3 pages)

_____ Behavior Health Referral Checklist (1 page)

_____ Child Intake Form (5 pages)

_____ Copy of Driver's License

_____ Copy of Insurance Card

_____ Your preferred method of Payment

___ Cash ___ Debit/Credit ___ CashApp (_____) ___ Vemno (_____)

___ PayPal ___ Invoice (provide email) _____

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

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.

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. 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

Shalonda D. Carlisle, LCSW,M.S Edu
357 Towne Centre, Ridgeland, MS 39157
601-559-0599
Hours of Operation
Monday through Friday 5:00pm to 8:00pm
Saturday 8:00am to 5:00pm

To whom it may concern:

In an effort to prevent duplication of services, Carlisle Counseling & Consulting Services, LLC has asked that you refrain from seeking counseling services for your child from multiple therapeutic service providers**.** For example, if your child is receiving services from Carlisle Counseling Consulting Services and any other therapeutic counseling provider. This is considered a duplication of services due to both entities providing therapy.

You will be required to pay any out of pocket expenses incurred should your medical coverage deny payment. If you have any further questions, please contact me at carlisleforgrowth@yahoo.com or (601)559-0599.

Sincerely,

Shalonda D. Carlisle, LCSW, M.S.Edu

Shalonda D. Carlisle, LCSW,M.S Edu
Licensed Clinical Social Worker

Consent for Treatment

Shalonda D. Carlisle, LCSW

Carlisle Counseling & Consulting Services, LLC

357 Towne Centre, Suite 402

Ridgeland, MS 39157

601-559-0599 Office

I have chosen to receive mental health services in the form of counseling/therapy for myself _____ and/or my child _____from Shalonda D. Carlisle, LCSW. 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 in order 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 [Company] provider(s) to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed
3. The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others
4. Other special circumstances, such as preparation to testify in court

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

- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievance about the agency or staff
- The right to confidentiality of clinical records and personal information according to federal and state laws

Emergencies

I understand I may reach 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 situation, I may call 911 or go to the nearest emergency room for evaluation and treatment.

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

_____

Signature / Date

_____

Witness / Date

Shalonda D. Carlisle, LCSW

Carlisle Counseling & Consulting Services, LLC

357 Towne Centre, Suite 402

Ridgeland, MS 39157

601-559-0599 Office

Consent to File Insurance

Patient/Guardian Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered by Shalonda D. Carlisle, LCSW 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 of 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. Shalonda D. Carlisle, LCSW provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____ _____

Printed Patient Name Patient or Guardian Signature Date

(Child and Guardian Name if applicable)

_____

Witness

I give permission to communicate my Private Healthcare Information to:

_____ _____ Name

Relationship

_____ _____ Name

Relationship

_____ _____ Name

Relationship

Our office does not make the rules. They are determined by your specific medical insurance plan.

It is important that you read and acknowledge our Policies and Procedures in full.

Policies and Procedures

Payment in full for services are due at the time services are performed. As the patient/guarantor, you are financially responsible for any fees and costs associated with any services you receive from our office.

Co-payments will be collected at the time of service. Professional fees, services fees, copayments and deductibles are NOT refundable. There will be a $40.00 fee for returned checks.

As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. 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.

If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours when possible, or prior to appointment time on the same day in an emergency situation) so that we may open your reserved time for another patient; failure to do so will result in a $40.00 charge. If you miss two appointments without prior cancellation (24 hours when possible, or prior to appointment time on the same day in an emergency situation), you will be required to pay a $35.00 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time. When the appointment is kept, this $35 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.

_____ _____ _____

Printed Patient Name Patient or Guardian Signature Date

(Child and Guardian Name if applicable)

_____

Witness Date

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

To use or disclose the following health information: (check one)

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

The purpose of this authorization is: (check all that apply)

☐ - At my request

☐ - Other: _____

☐ - To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ - To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends: (check one)

☐ - On (date)_____

☐ - When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____

Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

Carlisle
COUNSELING & CONSULTING SERVICES, LLC

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: _____

Sholanda D. Carlisle, LCSW
Carlisle Counseling & Consulting Services LLC
357 Towne Centre, Suite 402
Ridgeland, MS 39157
601-559-0599 Office

CARLISLE COUNSELING & CONSULTING SERVICES,LLC

Behavioral Health Referral Check List

Please think of your child in several settings and complete this form.

Name: _____ School/Location: _____
Grade: _____ Date of Birth: _____ Insurance Type/Number: _____

___Often distracted
__Fails to give close attention to details
__Difficulty sustaining attention in tasks
__Picks at things (nails, clothing, hair, etc.)
__Talks back to authority figures (attitude)
__Often angry and resentful
__Wants to give orders
__Excitable or impulsive
__Difficulty or impulsive
__Cries easily
__Pouts and has a bad temper
__Sucks or chews thumb, finger, or clothing
__Does not seem to listen when spoken to directly
__Tendency to daydream
__Has a chip on his or her shoulder
__Often fidgets with hands or feet, squirms in seat
__Breaks things/destructive
__Shy and does not assert self
__Has stolen items (shoplifting)
__Blames others for their mistakes
__Argues with adults
__Disrespectful
__Talks excessively
__Often leaves seat in classroom
__Deliberately engaging in fire setting
__Broken into someone's house
__Truant from school
__Deliberately annoys people
__Broken into someone else's house

__Does not follow through on instructions
__Difficulty organizing tasks
__Often loses things necessary for tasks
__Worries unnecessarily
__Has problems with speech (stuttering, baby talk)
__Lies to obtain goods or favors
__Experiences fear and anxiety in new situations
__Does not follow rules, makes wrong decisions
__Often runs about or climbs excessively
__Forced someone into sexual activity
__Blurts out answers before questions have been asked
__Has difficulty awaiting their turn
__Often interrupts or intrudes on others
__Often forgetful in daily activities
__Physically cruel to people/animals
__Often loses temper
__ Poor personal hygiene habits
__Often bullies, threatens, or intimidates
__Used weapons to cause physical harm to others
__Reserved, a loner, unusually quiet, or sad
__Has a learning disability or IEP
__Sneaks to use alcohol/drugs/cigarettes/etc.
__Often has difficulty playing or engaging in leisure activities
__Often avoids or dislikes mental effort activities
__Deliberately destroyed others' property
__Runs away from home overnight at least twice
__Stays out at night despite parental prohibitions
__Often defies or refuses to comply with adults' rules
__Often initiates physical fights

Parent Name:_____ Phone Number:_____DATE:_____

CARLISLE COUNSELING & CONSULTING, LLC

CHILD INTAKE

Patient name: _____ Age: _____ Date of Birth: ____/____/_____

Name of person completing form: _____

Relationship to Child: _____ Today's Date: ____/____/_____

School: _____ Grade: _____

Race: _____ Ethnicity: _____

Parent: _____ Mother / Father / Guardian
(last name) (first name)

Parent: _____ Mother / Father / Guardian
(last name) (first name)

Parent relationship: ___ partners ___ married ___ separated ___ divorced ___ widowed

If separated or divorced, provide date of separation: _____

If widowed, date of death: _____

Sibling(s) (name/age): _____

Who suggested that you seek assessment and/or counseling for your child?

___ School teacher ___ School counselor ___ Myself as a caregiver ___ Other: _____

Describe the overall problem that led you to seek help for your child:

_____

_____

_____

My child has difficulty with a relationship in our family (parent, sibling, parent's partner): Yes No

If yes, who: _____

I have reason to suspect my child has been abused (emotionally, sexually, and/or physically): Yes No

If yes, please explain:_____

Describe your child's school experience:

_____

_____

Describe your child's interactions with his/her parents or guardians:

_____

_____

Describe your child's interactions with siblings:

_____

_____

Describe your child's ability to complete tasks and follow directions:

_____

_____

I would describe my child as: Independent Dependent

Explain: _____

_____

My child appears to have high levels of stress: Yes No

If yes, explain: _____

_____

Describe your child's sleep patterns:

_____

_____

Describe your child's eating patterns:

_____

_____

Describe your child's physical activity level:

_____

_____

Medical History

Birth: Duration of labor: _____

Type of delivery: _____

Difficulties: _____

How soon did the mother see baby? _____

Birth weight: _____

Infancy: Age of weaning: _____

Feeding problems? _____

Approximate age of walking: _____

Approximate age of talking: _____

Sleep problems? Yes No

If yes, please explain: _____

Any behavior such as head banging, rocking, etc.? Yes No

If yes, please explain: _____

Does your child have difficulty separating from his/her parents? Yes No

If yes, please explain: _____

Has your child had any severe, long-term illnesses or accidents? Yes No

If yes, please explain: _____

Is your child on any medication? Yes No

If yes, please explain: _____

Does your child have any digestive problems? Yes No

If yes, please explain: _____

Does your child have any allergies? Yes No

If yes, please explain: _____

Does your child have any physical pain? Yes No

If yes, please explain: _____

Does your child ever appear disoriented or dizzy? Yes No

If yes, please explain: _____

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate family member/relation affected.

Autism Yes No _____

Attention Deficit	Yes	No	_____
Depression	Yes	No	_____
Anxiety Disorder	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____
Other			_____

Any other information you would like to share?

_____

_____

_____