CLIENT INFORMATION

Family's Last Name: _____ Date: _____

Person completing this form _____ Relationship to Client: _____

Who referred you to Jim Brown? _____

May I thank him/her for the referral? YES NO (Circle One)

FAMILY INFORMATION

(NOTE: Include yourself in the following) If you are or have been married, complete for that family. If you are single, complete for your birth family *including yourself.* Begin with adults, and then children, oldest to youngest.

NAME (first & last)	DATE OF BIRTH	SEX	RELATIONSHIP

Home Address _____ Phone _____

City _____ State _____ Zip _____ Cell/Pager _____

EMPLOYMENT

Adult Male _____ Phone _____

Adult Female _____ Phone _____

May I call you at home? Yes No **May I call you at work?** Yes No **May I call a cell #?** Yes No

SOCIAL SECURITY NUMBERS

Male _____ Female _____

In your own words, please state the problem that brings you to this office:

_____

_____

_____

_____

_____

_____

MEDICAL AND PSYCHOTHERAPY HISTORY

Have you or anyone in the list above been in therapy or counseling before (Circle one) YES or NO. If "Yes," list below:

NAME	WHEN	WITH WHOM?	WHAT FOR?

Are you or anyone in the list above currently on medication (Circle) YES or NO If "Yes," list below:

NAME	MEDICATION	WHAT FOR?	DOSAGE	PHYSICIAN

FAMILY PHYSICIAN: Name _____ Phone # _____

Specialists: If you or anyone in your family is presently seeing a specialist (urologist, allergist, etc.) please provide the following information:

SPECIALIST: Name_____ Phone # _____

FAMILY MEMBER: _____ Reason _____

PAYMENT INFORMATION: Read **"Fee Information and Agreement Form"** before completing this part:

Who will be responsible for payment? _____

IF YOU EXPECT INSURANCE TO COVER YOUR FEES:

a. Which family member has the policy? _____

b. What is the Insurance Company name? _____

c. Policy Plan or Number: _____

Deductible: _____ % covered: _____

Client Information

Please rate the items below that are of concern to you.

0	1	2	3	4	5
Not at All	a little		somewhat of concern		very much a problem

_____ 1. Not being the kind of person I want to be.
_____ 2. Too tired to do anything.
_____ 3. Unhappy with my physical appearance/weight.
_____ 4. Discouraged about my future.
_____ 5. Financial problems.
_____ 6. Dissatisfied or bored with everything.
_____ 7. Concerned about physical health.
_____ 8. Feeling guilty a lot.
_____ 9. Concerned over my living situation.
_____ 10. Being ill at ease at social gatherings.
_____ 11. Having difficulty making decisions.
_____ 12. Eating problems.
_____ 13. Sleep problems.
_____ 14. Feeling like others do not like me.
_____ 15. Thoughts of suicide.
_____ 16. Intent to commit suicide.
_____ 17. Thoughts of hurting someone else.
_____ 18. Worrying excessively.
_____ 19. Unable to concentrate.
_____ 20. Feeling that no one understands me.
_____ 21. Nervousness.
_____ 22. Relationship problems.
_____ 23. Sexual Concerns.
_____ 24. Headaches.
_____ 25. Lacking love and affection.
_____ 26. Pressure from others.
_____ 27. Family problems.
_____ 28. Belonging to a minority group.
_____ 29. Confused in my religious beliefs.
_____ 30. Fearing failure or rejection.
_____ 31. Having difficulty trusting others.
_____ 32. Feeling inferior.
_____ 33. Getting into too many arguments.
_____ 34. Too easily influenced by others.
_____ 35. Concerned about my use of drugs or alcohol.
_____ 36. Feeling a great sense of loss or grief.
_____ 37. Wonder whether to get married.
_____ 38. Problems at work.
_____ 39. Unsure of my education/career choices.
_____ 40. Feel I’m a complete blank; I don’t know.

GENERAL INFORMATION AND CONSENT

For best results and your own welfare, it is important that you understand what it means to be in psychotherapy. Please read the brief description below. If you have any questions or concerns, you are urged to talk about them. If you understand it and you chose to be in psychotherapy as described here, **initial each point and sign and date this form**. Your signature represents an agreement between us.

1. Psychotherapy is a special kind of health care service. The goals of psychotherapy are to help you better understand yourself and others, to help you solve problems that may be limiting your life satisfaction, and to help you better cope with the feelings and challenges that you encounter in your daily life. **I understand: _____ yes _____ no**

2. The most common form of psychotherapy involves your talking about your feelings, your problems or concerns, and your experience of yourself and your situation. Other common methods involve using your imagination, keeping personal records of your experiences, and trying new or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions or you may be asked to do them at home. **I understand: _____ yes _____ no**

3. To better understand you, many psychotherapists use a variety of tests or measures of your current abilities and styles of experiencing. These measures are important in choosing the treatment methods best suited to you, and they are also helpful in estimating your progress.
   I understand: _____ yes _____ no

4. The length of psychotherapy often depends upon your individual needs and the rate of your progress. Many therapists use periodic reviews as a means of evaluating your needs, progress, and satisfaction. **I understand: _____ yes _____ no**

5. Most people benefit from psychotherapy. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in psychotherapy. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by psychotherapy is rare, but you should be aware that it could happen. The most common causes of such damage are poor communication or unethical conduct. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in psychotherapy, you should discuss this with your therapist. If you feel that your therapist has attempted to violate you in any way -- financially, physically, sexually, or otherwise -- you should so inform the state agency responsible for professional licensing. **I understand: _____ yes _____ no**

6. You always have the right to choose whether or not to continue in psychotherapy. If you feel that you might work better with a different therapist, your present therapist should be able to offer you information on possible referrals. Local mental health agencies are listed in the phone book and they may also offer helpful information. The most common alternatives to psychotherapy are self-help and support groups, bibliotherapy (therapeutic reading), and different forms of religious counseling. **I understand: _____ yes _____ no**

7. The information communicated in therapy must be kept confidential by your therapist unless you grant permission to release it. The only exceptions to this protection of your privacy are dictated by state laws.

Confidential information may be released WITHOUT your permission if:

- You threaten to harm yourself or someone else and your threat is believed to be serious, your therapist is ethically and in some instances legally obligated to take whatever action seems necessary to protect you or others from harm.

- There is suspected child abuse or neglect. Therapists are obligated by law to report this to the appropriate state agency. This law also applies if you report that you have reason to believe another person is abusing or neglecting a child.

- You are in court-ordered therapy you can assume that the court wishes to receive some type report or evaluation.

- You are involved in litigation of any kind and inform the court of the services you received here (MAKING YOUR MENTAL HEALTH AN ISSUE BEFORE THE COURT), you may be waiving your right to keep your records confidential.

- You lodge a formal complaint against me or make me a party to a legal action.

- You use insurance to reimburse for fees (please see Release of information Form for Insurance Purposes).

- You do not pay your bill and billing information is forwarded to a collection agent.

  I understand: _____ yes _____ no

8. I understand that my therapeutic relationship is with Jim Brown, MDiv, MA. Although the location is at 2611 River Drive and other independent therapists practice at this location, I agree to hold harmless any other service provider at this location.
   I understand: _____ yes _____ no

Your signature below indicates that you have read and understood the above description of psychotherapy. Your signature also indicates that you are now consenting to be in psychotherapy with the understanding that you retain the right to review and revise this decision at later points in time.

_____ _____

Signature of Client or Parent/Guardian Date

South Carolina provides the consumer the opportunity to file inquiries with its Board of Examiners for Licensure for PC, MFT & PES. Board offices may be reached at: **South Carolina Board of Examiners in Psychology, P.O. Box 11329, Columbia, SC 29211-1329**

CONSENT FOR SPECIAL CIRCUMSTANCES

CHILDREN AND ADOLESCENTS AGES 15 AND UNDER:

At these ages, child clients are considered dependents and confidentiality belongs to the legal parent/guardian(s). It should be explained to a child that there is a difference between privacy and confidentiality; therefore, a child can expect that their communications be kept private unless it is the judgment of the therapist that parents need to be brought in on a particular issue. Examples might include (but are not limited to), safety concerns, medical issues, family dynamics, or other situations in which the parent may be needed as a resource.

CHILDREN OF DIVORCED/SEPARATED PARENTS:

Although these situations can be difficult and delicate, there are certain legal and ethical guidelines that I follow.

- **CONSENT FOR TREATMENT MUST BE OBTAINED FROM BOTH PARENTS** unless sole legal custody is documented. I will require that a copy of this document be kept in my file.
- Unless sole custody is established, both parents have a right to communicate with me regarding treatment issues. I have the right to communicate with either/both parents regarding treatment issues based on my clinical judgment. All written communications will be copied to both parents.
- Because the child is the client, it is my job to work as an advocate for the welfare of the child. Unresolved marital conflicts may require treatment in another therapeutic setting.
  I understand or have discussed any questions:

Parent signature _____ **Date** _____

Parent signature _____ **Date** _____

Child signature _____ **Date** _____

ADOLESCENTS AGES 16,17,18 YEARS OLD and SOME COLLEGE STUDENTS:

At these ages in SC, confidentiality belongs to the client. I am aware that in most cases, children may still legally dependent, living at home, and those parents are likely paying for therapy; nonetheless, this is the law. **I MUST HAVE THE WRITTEN CONSENT OF THE CLIENT TO COMMUNICATE WITH PARENTS.**

It is my general philosophy to facilitate communication between adolescents and their families and will attempt to bring parents' concerns into the therapy. When I deem it clinically important, periodic family meetings will be requested.

If an adolescent client is engaged in risky behavior, I operate under the same principles that apply to adult clients, working toward therapeutic remediation of the problem. The dangerousness of the behavior is a clinical judgment and in circumstance in which an adolescent refuses to cooperate with treatment recommendations, it may be necessary to terminate treatment.

Information received from parents via phone calls, voice mail, written communication will not generally be kept secret as this impedes the therapeutic process and relationship.
I understand or have discussed any questions.

Client signature _____ **Date** _____

Parent signature _____ **Date** _____

COUPLES THERAPY:

The purpose of therapy is for reconciliation and healing and is at cross-purposes of a legal action,, which is adversarial by definition. No information may be released for either party without the written consent of both parties because technically, the relationship is the client. This makes all information from the therapy available to both sides. Therefore, I find it in the best interest of the therapeutic process for both parties to agree not to subpoena the therapist for either side in the event of a divorce or custody trial.

I agree not to subpoena therapy records in the event of a legal proceeding.

Signature _____ **Date** _____

Signature _____ **Date** _____

Additionally, information received from either party via phone calls, voice mail, written communication will not generally be kept secret as this impedes the therapeutic process and relationship.

Both Parties Please Initial: **I understand: _____ yes _____ no I understand: _____ yes _____ no**

FAMILY THERAPY:

In family therapy, the family is the client. No information may be released without the written consent of all parties to whom confidentiality belongs. As outlined in the couples' therapy section (above), I find it in the best interest of the therapeutic process for all parties to agree not to subpoena the therapist in the event of a legal proceeding.

I agree not to subpoena therapy records in the event of a legal proceeding.

Signature _____ **Date** _____

Signature _____ **Date** _____

Signature _____ **Date** _____

Signature _____ **Date** _____

Additionally, information received from any party via phone calls, voice mail, written communication will not generally be kept secret as this impedes the therapeutic process and relationship.
All parties please initial: **I understand _____ yes _____ no**

COMMUNICATION GUIDELINES

FACEBOOK & OTHER SMS:

I will not accept Facebook or other social media sights Friend Request from you or send them to you while you are an active client.

I understand _____ yes _____ no

EMAIL:

Email is to be used only for the purposes of scheduling appointments and sending reminders. We make take as long as 24 hours to respond. Regarding canceling an appointment, 24 working hours notice is required for email notification, as well as for notification by phone.

Email is not to be used to communicate emergency or therapeutic information. If you do send me information via email, know that it is confidential within our office. However, all communication via the internet is not considered secure and also becomes a part of your permanent file.

I understand _____ yes _____ no

Texting:

I do not use texting as a form of communication. Texting, like email, is not secure. If you would like to text regarding appointments, that is acceptable, as long as there is no confidential or therapeutic information contained within the text. However, all communication via the internet is not considered secure and also becomes a part of your permanent file.

I understand _____ yes _____ no

RELEASE OF INFORMATION FORM
for
INSURANCE PURPOSES

I hereby authorize Jim Brown to furnish information to my insurance carriers concerning diagnosis and treatment and hereby assign to Jim Brown all payments for services. I understand that I am responsible for an amount not covered by my insurance. I authorize the use of a photocopy of this assignment in lieu of the original when necessary.

NAME IN PRINT: _____

SIGNATURE: _____ **DATE** _____

I also consent and hereby give Jim Brown permission to file claims and provide documentation over the internet for insurance purposes. YES _____ NO _____

FEES, PAYMENT, INSURANCE AND APPOINTMENTS

FEES:	**$150**	Initial Consultation
	$130	Per 50-minute session
	$110	Per 50-minute co-therapy or consultation session (Two therapists; the other therapist's fee is separate)
	$160	Per hour for weekends (1.5-hour minimum)
	$45	Per 15-minute phone conversation requiring the therapist
Legal Consults:	**$350**	Per hour or quarter hours for legal documents, court preparation, phone consultations and travel time.

INITIAL CONSULTATION: Your first appointment is not automatically the first of many. It is intended to give you a first look at the process of therapy and at your therapist, and to provide you with enough information to clarify both your intention to enter therapy, and some goals for its outcome and some of the time will be spent going over the paperwork along with clarifying any insurance issues.

PAYMENT: Please pay your fee when you come in, or at the end of each session. Ledger statements can be provided on request. Make your check payable to Jim Brown.

INSURANCE CLAIMS: I do not bill insurance companies directly. I will provide you with a "superbill" such as physicians use in exchange for the fee at each session. In certain cases and with certain companies, I must bill the insurance company directly. I will let you know, if this is the case. Otherwise, I will provide the necessary information you may file the claim yourself.

INSURANCE COVERAGE: * Your health insurance policy may cover all or part of our fees, or it may not. Insurance companies often place confusing restrictions on place and/or provider of mental heath services. I will be glad to help you interpret your policy. However, if you expect insurance to cover my services, you should get confirmation directly from your carrier. In any case, ***you are responsible for payment of fees whether your insurance covers them or not***.

MANAGED CARE/HMOs/EAPs: I accept the coverage and payment arrangement of organizations for which I am a provider.

APPOINTMENTS: Though regular appointment times can be scheduled for some clients, I usually manage appointments based on the unique scheduling and treatment needs of each client. Evening and weekend appointments are available. (See **FEES** above.)

CANCELING APPOINTMENTS: I ask that you give me 24 hours' notice if you need to cancel or reschedule. Your appointment is yours alone. Without prior notice it cannot be given to anyone else. ***You will be charged the regular fee for appointments missed without* 24 *hours' notice.***

*** Please be aware** that using insurance to cover mental health fees is an automatic Release of Information to your insurance company. See the page regarding Confidentiality included in your intake materials for more information.

James H. Brown, PhD, LPCS

P.O. Box 2647
Irmo, SC 29063
Phone: 803-917-8773
Fax: 803-771-6685
Email: jbrown@jimbrownlpc.com

FEE AGREEMENT

I, _____, understand that services are delivered by James H. Brown, LPC in good faith and that payment will be made in accordance with the information listed on FEES, PAYMENT, INSURANCE AND APPOINTMENTS form. I understand that "no shows" and cancellations made without 24 hours notice will be billed at full fee and that insurance cannot be filed. Balances not paid within 30 days will be subject to a 1.5% interest charge. Balances over 60 days will be subject to a 2.5% interest charge and a $25.00 statement fee for each monthly statement. Accounts over 90 days delinquent are subject to collections.

_____ _____
Signature of party responsible for payment Date

EXTENDED FEE PAYMENT AGREEMENT

In circumstances of unusual financial hardship, it may be possible to negotiate a fee reduction or payment installment plan.

I, _____, agree to pay James H. Brown, LPC $_____ per week/biweekly/monthly, until the outstanding balance on my account is zero.

_____ _____
Signature of party responsible for payment Date

_____ _____
Signature of Therapist Date

Jim Brown, PhD
2611 River Drive
Columbia, SC 29201
803 917-8773

DATE:

TO:

SUBECT: Denial of insurance claims

Dear Client:

It is my personal opinion that insurance companies often make "mistakes" in denying claims. You may be getting this letter because I just got a copy of such a denial from *your* insurance company. In my practice, I have repeatedly heard from clients who persist in presenting claims that such "mistakes" are later acknowledged, and the c1aim is eventually paid.

Below is an approach to "persisting" that's a blend of how some of my clients and I, personally, have persisted successfully. Perhaps it will work for you too.

1. Many insurance companies require a doctor's referral for mental health services to be covered. Know this ahead of time, and be sure to get it if needed.
2. Be sure to copy your claims (and the doctor's referral if appropriate) before sending them.
3. If a claim is denied, call your insurance company and get a name, phone number, and specific address of a specific person assigned to review your claim. If you have to, ask to speak to successive supervisors until you get that name.
4. Make a copy of the copy and send it Certified Mail/Return Receipt to the person whose name you have, with a cover letter saying why you believe the denial is wrong, and asking for review of the claim and a for specific, personal, written response.
5. If the claim is still denied and you still think it should be covered, send copies of everything (including your policy) to your lawyer with a cover letter asking him to review it and give you an opinion. Mail a copy of the cover letter to the person assigned to your case, also Certified Mail.

Many "mistakes" have been discovered somewhere from step 3 through step 5. If this happens for you, I'm sure your insurance company will be grateful to you for helping them be fair.

Sincerely,

Jim Brown, PhD