



Lumina Counseling Associates PLLC

CLIENT REGISTRATION FORM

FILE NO. _____

CLIENT _____

ADDRESS _____

CELL _____ HM _____ WK _____

EMAIL _____

DOB _____ AGE _____

EMPLOYER _____

EMERGENCY CONTACT NAME _____

PHONE _____ RELATIONSHIP _____

PARTNER NAME _____ PHONE _____

FOR MINORS: PARENTS _____ MARRIED _____ SEPARATED _____ DIVORCED

MOTHER NAME _____

CELL _____ EMAIL _____

FATHER NAME _____

CELL _____ EMAIL _____

SCHOOL _____ GRADE _____

CLIENT SIGNATURE _____

DATE _____

RESPONSIBLE PARTY FOR MINOR _____

RELATIONSHIP _____



Lumina Counseling Associates PLLC

INTAKE INFORMATION

PG 1 OF 2

FILE NO. _____

CLIENT _____

DOB _____

WHAT WOULD YOU LIKE TO DISCUSS AT THE INTAKE APPOINTMENT? _____

ARE YOU CURRENTLY BEING SEEN BY ANY OTHER MENTAL HEALTH PROFESSIONAL? _____

NAME: _____

HAVE YOU SEEN A MENTAL HEALTH PROFESSIONAL IN THE PAST? PLEASE LIST YEAR AND FOR WHAT REASON. _____

PLEASE LIST PSYCHIATRIC MEDICATIONS CURRENTLY PRESCRIBED: _____

PRESCRIBING PHYSICIAN NAME: _____

PRIMARY CARE PHYSICIAN: _____

OB/GYN PHYSICIAN: _____

HAVE YOU EVER RECEIVED A MENTAL HEALTH DIAGNOSIS? IF YES, PLEASE EXPLAIN. _____

HAVE YOU EVER BEEN HOSPITALIZED FOR A MENTAL HEALTH CONCERN? IF YES, PLEASE EXPLAIN. _____

HAVE YOU EVER EXPERIENCED SUICIDAL THOUGHTS PAST OR PRESENT? IF YES, PLEASE EXPLAIN. _____

WHAT ARE YOUR GOALS FOR THERAPY? _____



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INTAKE INFORMATION

PG 2 OF 2

FILE NO. _____

CLIENT _____

DOB _____

SYMPTOM CHECKLIST: PLEASE CHECK ALL THAT APPLY PAST OR PRESENT.

- ACADEMIC CONCERNS
- ADD/ADHD
- AGGRESSION/ANGER
- ANXIETY
- BLAMING/CRITICIZING SELF
- BLENDED FAMILY
- CAREER STRESS
- COMMUNICATION ISSUES
- DIVORCE
- FAMILY STRESS
- HALLUCINATIONS
- HEADACHES
- INFIDELITY
- IRRITABILITY
- ISOLATING BEHAVIORS
- JUDGMENT ERRORS
- LACK OF INTEREST
- LEARNING DISABILITY
- LOSS
- MEMORY IMPAIRMENT
- MENSTRUAL RELATED CONCERNS
- NEUROLOGICAL CONCERNS
- PANIC ATTACKS
- PHOBIAS/FEARS
- POOR SELF ESTEEM
- RELATIONSHIP CHALLENGES
- SADNESS/DEPRESSION
- SEIZURES
- SEXUAL/SEXUALITY RELATED CONCERNS
- SLEEP ISSUES
- SOCIAL AWKWARDNESS/ANXIETY
- STOMACH ACHES
- SUBSTANCE USE CONCERNS
- SUICIDAL THOUGHTS
- TICS
- TRAUMA

DO YOU EXERCISE? _____ FREQUENCY? _____

RECENT CHANGES IN APPETITE OR SLEEP? _____ PLEASE EXPLAIN. _____

DO YOU ENGAGE IN OR HAVE A HISTORY OF SELF HARMING BEHAVIORS? _____

PLEASE EXPLAIN. _____

PLEASE LIST ALL PHYSICAL HEALTH CONDITIONS: _____

PLEASE DETAIL ANY FAMILY HISTORY OF MENTAL HEALTH CONCERNS: _____



Lumina Counseling Associates PLLC

Authorization for Release of Information

Client Information:

File No. _____

Name of Client: _____ DOB _____

Responsible Party (if different from above): _____

Lumina Counseling Associates PLLC is authorized to release protected health information pertaining to the above named patient to the entities below.

Entity to Receive Information. (Circle ALL you authorize)

Client Only

Spouse

Parents

Emergency Contact

Provide information to the following additional persons (ie health care physicians, mental health providers):

Name _____

Relationship _____

Name _____

Relationship _____

Description of information to be released.

- Appointment Information (appointment history, next scheduled appointment, scheduling changes)
- Insurance/Financial Information (payment/billing information, receipts)
- Treatment Related Information

Communication Methods. (Circle ALL you authorize)

Email _____

Voice/Text Messages _____

Appt. Reminders: Text Email

Client Portal

In case of therapist emergency cancellation, please select a communication method:

Email

Voicemail Message

Text Message

Rights of the Client

I understand that I have the right to revoke this authorization at any time by sending written verification. I understand that a revocation is not effective in case where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to: Lumina Counseling Assoc., 610 W. Peace St. Raleigh, NC 27605.

I understand that text and email communications are not guaranteed to be secure and could result in a breach of confidentiality of my protected health information. Lumina Counseling is not responsible for information breaches attributed to these client authorized methods of communication.

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

Signature: _____ Date: _____



Lumina Counseling Associates PLLC

FINANCIAL POLICIES

FILE NO. _____

NAME _____

DOB _____

Private Pay Rates: \$200 - 90 min Intake Session \$150 - 60 min Session

Cancellation Policy

When scheduling please be aware that you are reserving time in advance, and as such you will be subject to a \$75 fee for any scheduled appointments that are missed, re-scheduled or cancelled with less than 24 hours prior notice.

Private pay services qualify for flex/health spending account and out of network reimbursement if your insurance plan provides that benefit.

IF YOU REQUIRE A MONTHLY INSURANCE REIMBURSEMENT RECEIPT, PLEASE INITIAL HERE. _____

Insurance Information

THIS PRACTICE DOES NOT ACCEPT INSURANCE AND IS NOT IN NETWORK WITH ANY INSURANCE CARRIER.

Do you currently have health insurance? _____ Do you plan to submit an insurance claim? _____

Payment Policy

LUMINA COUNSELING UTILIZES SQUARE FOR ALL CREDIT CARD PROCESSING. YOU WILL RECEIVE A RECEIPT FOR EACH TRANSACTION VIA EMAIL.

CREDIT AUTHORIZATION: A CREDIT CARD ON FILE IS REQUIRED TO SCHEDULE APPOINTMENTS. THE CARD WILL BE CHARGED FOR SESSION FEES IF CLIENT DOES NOT PROVIDE PAYMENT AT THE TIME OF THE SESSION AS WELL AS ANY ADDITIONAL FEES INCURRED ON THE ACCOUNT.

SHOULD YOUR CARD ON FILE EXPIRE OR DECLINE CHARGES, YOU WILL RECEIVE AN INVOICE VIA EMAIL FROM SQUARE REQUESTING ONLINE PAYMENT. FOR YOUR CONVENIENCE, YOU MAY REQUEST TO BE BILLED FOR SERVICES MONTHLY PAYABLE ONLINE. SUCH REQUESTS WILL BE EVALUATED ON AN INDIVIDUAL BASIS SUBJECT TO APPROVAL.

CARD NO. _____

EXP CVV ZIP CODE

I AUTHORIZE LUMINA COUNSELING TO CHARGE MY CREDIT CARD ON FILE FOR ANY FEES ASSOCIATED WITH THERAPY SERVICES INCLUDING BUT NOT LIMITED TO SESSION FEES, LATE CANCELLATION/RE-SCHEDULE FEES, MISSED APPOINTMENT FEES AND COURT FEES. I CAN REVOKE THIS AGREEMENT AT ANY TIME WITH A WRITTEN STATEMENT INDICATING AN ALTERNATE PAYMENT ARRANGEMENT.

RESPONSIBLE PARTY _____

DATE _____