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? _____

_____

_____

_____

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 Voicemail Messages Text Messages Appt. Reminders 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

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

Out of Network Reimbursement requires payment at the time of service at which time you will receive a reimbursement form to file with your insurance company. You will receive the reimbursement check. You can check your **out of network** coverage by asking your insurance company the following questions:

- Do I have mental health insurance benefits?
- What is my **out of network** benefit? If so, what is the deductible?
- What form or receipt do I need for reimbursement?
- Where do I send my form for reimbursement?

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.**

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

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

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.

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