Lumina Counseling Associates PLLC

CLIENT REGISTRATION FORM FILE NO. ________________

CLIENT ____ DATE ____________

ADDRESS ____

CELL____________________ HM __________________ WK ______________________

EMAIL ____

AGE __________ DOB _______________ OCCUPATION ______________________

SCHOOL ____

IF CLIENT IS A MINOR, PARENT NAMES ___________________________________

MOTHER CELL _______________________ FATHER CELL_______________________

MOTHER EMAIL____

FATHER EMAIL____

SPOUSE NAME/PHONE____

EMERGENCY CONTACT NAME____

PHONE____

INSURANCE INFORMATION

RESPONSIBLE PARTY_____________________________ DOB____________________

EMPLOYER____

INSURANCE COMPANY ____

INSURANCE ID#____

____

CLIENT SIGNATURE DATE

____

RESPONSIBLE PARTY FOR MINOR RELATIONSHIP

Lumina Counseling Associates PLLC

INTAKE INFORMATION 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/PHONE NUMBER:____

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

____

DO YOU CURRENTLY TAKE PSYCHIATRIC MEDICATION?__________________________________

PRESCRIBING PHYSICIAN NAME/PHONE NUMBER:______________________________________

MEDICATION/DOSAGE:____

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? ____

____

____

____

____

Michelle Chiaramonte LCSW 610 W. Peace St. Raleigh, NC 27605 www.luminacounseling.com
919.527.0592

Lumina Counseling Associates PLLC

INTAKE INFORMATION 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

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 redisclosure 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:________________

FINANCIAL POLICIES FILE NO. ________________

NAME____ DOB________________

LUMINA COUNSELING PARTICIPATES IN-NETWORK WITH BLUE CROSS BLUE SHIELD INSURANCE & CIGNA, **EXCEPT BLUEVALUE & BLUELOCAL** PLANS. IF YOU ARE UTILIZING INSURANCE BENEFITS, LUMINA COUNSELING WILL SUBMIT THE CLAIM FOR PAYMENT. ONCE THE FIRST CLAIM HAS BEEN ADJUDICATED, YOU WILL BE NOTIFIED OF THE PORTION YOU ARE RESPONSIBLE FOR. LUMINA COUNSELING **DOES NOT** CONTACT INSURANCE PRIOR TO TREATMENT TO VERIFY BENEFITS, DEDUCTIBLES OR CO-PAYS FOR OUTPATIENT MENTAL HEALTH BENEFITS. *IT IS THE CLIENT'S RESPONSIBILITY TO UNDERSTAND THE FINANCIAL COST OF TREATMENT BEFORE COMMENCING SERVICES*.

IF YOU ARE COVERED BY ANOTHER INSURANCE CARRIER, LUMINA COUNSELING CANNOT FILE ANY CLAIMS FOR YOU. PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE.

MISSED APPOINTMENTS AND/OR CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE WILL RESULT IN A $50 FEE.

LUMINA COUNSELING UTILIZES SQUARE FOR ALL CREDIT CARD PROCESSING. YOU WILL RECEIVE A RECEIPT FOR EACH TRANSACTION VIA EMAIL. *DUE TO INSURANCE RESPONSE TIMES, THE CHARGE FOR SERVICES MAY BE UP TO 30 DAYS AFTER THE DATE OF SERVICE*.

IF YOU REQUIRE A MORE DETAILED RECEIPT FOR REIMBURSEMENT, PLEASE INITIAL HERE. _________

RATE INFORMATION (additional rates available on website www.luminacounseling.com)

INITIAL 60-75 MINS: $150 INDIVIDUAL 60 MINS: $110 COUPLE/FAMILY 60 MINS: $135

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RESPONSIBLE PARTY DATE

CREDIT AUTHORIZATION: FOR YOUR CONVENIENCE, YOU MAY LEAVE A CREDIT CARD ON FILE FOR CHARGES. THIS INFORMATION WILL BE STORED IN YOUR CONFIDENTIAL FILE ONLY.

CARD NO. **EXP** **CVV**

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

____

RESPONSIBLE PARTY DATE

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