Laura T. Ashford, LCSW, PLLC
523 Keisler Dr. Suite 103
Cary NC 27518
919-971-8732
Tax ID# 20-2034905

Confidential Request for Treatment

Name____ **DOB** _________________**Age**_________
Address____ **Phone**_____________________________
____ **Email**_______________ __ _____________

Responsible Party__________________________________ **DOB**_________________ ____ __________
Relationship to Client______________________________ **Phone**_______________ _ _____________
Address____ **Email**_ ______________________________

Insurance____ **Employer**__________________________
Policy #_____ ___________________________________ **Group#**____________________________
Authorization # _________________________________ **Filing #**____________________________
Emergency Contact___________________________________ **Contact #**_________________________

Concerns for requesting treatment today/Problematic symptoms:
____
____

Current Marital Status_____________, **Divorces**_____________, **Separation time period**___________
Children: ____
Others living in the home: ____

Please indicate any of the following:

__Sadness
__Crying
__Loss of Energy
__Loss of Motivation
__Hopeless
__Helpless
__Anxious
__Medical Complications
__Social Isolation
__Discipline Problems
__Communication Needs
__Eating Problems
__Impulsivity

__Increased Anger
__Easily Frustrated
__Distracted
__Change in Sleep
__Change in Appetite
__Self-Harmful Thoughts
__Harmful of others
__Disturbing Dreams
__Falling Grades
__Disorganized
__Relationship Problems
__Panic
__Increased Spending

__Substance Use
__Hearing Voices
__Visual Disturbances
__Racing Thoughts
__Abusive Behaviors
__Repetitive Behaviors
__Excessive Fears/Worries
__Decreased Performance
__Legal Involvement
__Sexual Concerns
__Financial Concerns
__Weight Change
__Employment Problems

Developmental History (for children):
____
____

Educational History:
Current School: ______________________________Grade: ___________Phone: ___________________
Contact Person/Teacher_______________________
Concerns:
____
____

Medical History and Allergies:
____
____

Current Medical Providers and Phone:
____
____

Current Medications:
____
____

Mental Health Treatment History: (Please indicate dates, providers and contact info):
____
____

Medications: (Past and current)
____
____

Family History of Mental Health and Substance Abuse:
____
____
____

Personal Substance Use: (alcohol, drugs; prescription and non-prescription)
____

Stressors affecting you or your family in the past 1-2 years:

__Death
__Births
__School
__Broken Relationship
__Marriage
__Step-children
__Unwanted Pregnancy
__Divorce
__Separation
__Substance Abuse
__Moving
__Physical Abuse
__Medical
__Chronic Illness
__Financial

Safety Policy
Weapons concealed or unconcealed are NOT allowed on the premises at any times.
By attending any in-person session, the client accepts responsibility for any transmission of illness to include but not limited to COVID-19 and the variants not yet identified. If any symptoms off illness are noted, it is the responsibility of the client to request virtual visits. Confidentiality cannot be maintained in the case of mandatory reporting due to such illness

Confidentiality:
Information regarding this treatment will remain confidential from individuals and entities outside of the guardian without specific verbal/written permission. The exceptions to this confidentiality policy are in the case of court order and suspicion of human danger in areas of suicide homicide or abuse. The “duty to warn” overrides the responsibility to maintain confidentiality. In accordance with HIPAA laws, the information may also be shared with necessary entities for the purposes of payment, treatment and operations of business. Electronic transmission; text and email are NOT confidential and are at the risk of the client by signing below.

After Hours and Emergency Care:
The phone will be answered daily. Messages may be left on voicemail and will be addressed within 48 hours. This is a cell phone number. There is no guarantee of confidentiality on the air waves. Text messages cannot be guaranteed confidential and both are used at the client’s own risk and responsibility. Any appointment changes should be made with a voice call. For medical emergency contact 911, Holly Hill Hospital 919-250-7000, Wakebrook Crisis Stabilization Center 984-974-4800 or go to your nearest hospital Emergency Dept.

Fee Agreement:
Payment is due at the time of service. The charge is $145 for diagnostic evaluation and $130 for a 55-60 minute psychotherapy session (individual, couple, family or play therapy). Cash, checks and Zelle are accepted forms of payment. A returned check fee of $25 will be added if applicable. Court services are billed at a rate of $200 per hour which will include telephone contacts, preparation, and travel, wait and testimony time. Fees are to be paid in advance as can be anticipated.

Insurance:
Filing of insurance claims is the responsibility of the patient unless prior arrangements are made. Permission is granted for the provider release any medical information necessary to process claims and to accept payment directly from the insurance carrier for the services provided. Payment of co-pay and co-insurance will be paid by patient at time of service.

Cancellation Policy:
Cancellation of an appointment MUST be made no less than 24 hours prior to the scheduled appointment time. Cancellation must be made in voice contact, NOT text form. Payment in full is expected for missed appointments contrary to this agreement.

Concerns and Complaints:
Concerns and Complaints of treatment are welcome and should be brought to discussion immediately for comfortable resolution or healthy referral. The above named provider is professionally separate and apart in practice and liability from any other service provider at this location.

I am in agreement with the above policies and understand that I am ultimately financially responsible for any debt incurred and consent to receive treatment for myself or minor for whom I have legal, medical responsibility

____________________________________ ____________________________
Client/legal guardian Date

I have seen, read and been offered a written copy of the HIPAA policies for these services.

____________________________________ ____________________________
Client/legal guardian Date

I have seen, read and been offered a written copy of the Notice of Privacy Practices for these services.

____________________________________ ____________________________
Client/legal guardian Date

Notice of Client Rights - Please this copy for yourself

You have the right to know about Laura T Ashford, LCSW and how business is handled, including:

-Names and Titles of the staff

-Services covered by your benefit plan

-How decisions are made about payment for treatment

-Your rights and responsibilities as a client

You have the right to know about Laura T Ashford, LCSW including:

-Clinical Licenses

-Specialties

-Office address, phone and hours

-Demographic information such as race or gender

You have the right to have information about your diagnosis and treatment kept confidential. Laura T Ashford LCSW, will only release information about diagnosis and treatment if you or your legal guardian provides verbal or written permission to do so. . However, sometimes the law requires Laura T Ashford, LCSW to release such information without: possible human harm, subpoena, necessary treatment

You have the right to be treated with respect, dignity and privacy, regardless of age, race, ethnicity, religion, disability, gender or sexual preference.

You have the right to be part of the decisions that are made about your plan of care.

You have the right to talk with your provider about the best treatment options for your condition, regardless of the cost of such care or benefit coverage.

You have the right to tell Laura T Ashford, LCSW what you think your rights and responsibilities should be

You have the right to make complaints about Laura T Ashford, LCSW, services or the care given.

You have the right to disagree with a decision made by Laura T Ashford LCSW about your care and/or to refuse services.

You have the right to receive timely care consistent with your need for care.

You have the right to know the facts about any charge or bill you receive.

Additional rights pertaining to your health Information are contained in the HIPAA **Notices of Privacy Practices**, which was provided to you at Intake and is available for review in the office during all working hours.

Grievance/Complaint Procedures

If you have any concerns regarding your rights, treatments, or privacy, please inform Laura T Ashford, LCSW at 919-971-8732 523 Keisler Dr. Suite 103 Cary NC 27518.

Additional resources include:

-Secretary of Health and Human Services, Independence Ave, SW Washington DC 20201
or by calling 202-619-0257

-Advocacy and Customer Service Section Division of MH/DD/SAS 3009 Mail Service Center Raleigh NC 27699, 919715-3197 or 800-662-3009, www.dhhs.gov/mhddsas

-The North Carolina Social Work Certification and Licensure Board at PO Box 1043 Asheboro NC 27204,
800-550-7009, http://www.ncswboard,org

This office will not retaliate against you for making a complaint.