Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Social Sec #_____-____-_____ Birth Date: ____ /____ /____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/ages: _____

_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) _____May we leave a message? □ Yes □ No

E-mail: _____May we email you? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

Are you currently taking any prescription medication?

□ Yes □ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ Yes □ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes

If yes, for approximately how long? _____

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

□ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship with 10 being the best? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:
In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____
_____
_____
_____

4. What do you consider to be some of your weaknesses?

_____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy?

_____
_____
_____
_____

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

Other Counseling or Therapy

Have you previously seen or are you currently seeing a counselor or therapist?

If so, please list the name of the counselor/therapist, the name of the agency, (if applicable), the topics of concern for which assistance was requested, and the time period for which counseling was conducted:

_____

_____

_____

_____

May we contact: □ No □ Yes

Counselor/Therapist Phone Number:_____

When were you last seen?_____

I give my consent for my therapist at Fresh Start Counseling to contact my prior counselors/therapists so that they can discuss my treatment.

SIGNATURE:_____DATE:_____

I **DO NOT** give my consent for my therapist at Fresh Start Counseling to contact my prior counselors/therapists so that they can discuss my treatment.

SIGNATURE:_____DATE:_____

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

Medical Information

Name of your primary care physician _____

May we contact: □ No □ Yes

Physician Phone Number:_____

When were you last seen?_____

I give my consent for my therapist at Fresh Start Counseling to release my record to my primary physician so that they can discuss my treatment. This release is effective for one year from the signed date unless terminated in writing.

SIGNATURE:_____DATE:_____

I **DO NOT** give my consent for my therapist at Fresh Start Counseling to release my record to my primary physician so that they can discuss my treatment.

SIGNATURE:_____DATE:_____

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

DRUG AND ALCOHOL ASSESSEMNT:

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office? _____Yes _____No

If yes _____Self _____Other:

Relationship_____

ALCOHOL ASSESSMENT:

Frequency of Alcohol use:

____Never _____Less than 1 time/month _____1-4 times per month _____ 2-3 times per week

_____Daily

Usual Alcohol Consumption:

_____None _____1-2 drinks per sitting _____3-4 drinks per sitting _____ 5 or more drinks per sitting

Frequency of use to levels of intoxication:

_____Never _____ less than 1 time/month _____ 1-4 times per month _____2-3 times per week

_____Daily

Please describe any alcohol-related problems (e.g. legal, job, physical, or social):

_____

_____

_____

_____

_____

_____

Self-perception of alcohol use: (check all that apply)

___Occasional or social ____Problem use ____Psychological dependence

___Addicted – cannot stop ____ Does not want to stop ____Motivated to stop

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

History of treatment attempts: (Check all that apply)

_____None _____Stopped on own _____Attended AA/Other 12 step program

____Attended outpatient program _____Attended inpatient program _____Attended community-based program

OTHER SUBSTANCE USE ASSESSMENT: (Check Frequency and Duration for each drug used in the last 6 months)

	Frequency			**Duration**	
	Daily	**Weekly**	**Monthly Or Less**	**Less than one year**	**More than one year**
Marijuana	_____	_____	_____	_____	_____
Sedative	_____	_____	_____	_____	_____
Stimulant	_____	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____	_____
Opiates	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____
Hallucinogens	_____	_____	_____	_____	_____
Prescription Drugs	_____	_____	_____	_____	_____

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

Caffeine _____Number of cups per day _____ Tobacco_____ If cigarettes- number per day _____

Please describe any drug-related problems (e.g. legal, job, physical, or social):

_____

_____

_____

_____

_____

_____

Self-perception of Drug Use: (Check all that apply)
___Occasional or social ____Problem use ____Psychological dependence
___Addicted – cannot stop ____ Does not want to stop ____Motivated to stop

History of treatment attempts: (Check all that apply)
_____None _____Stopped on own _____Attended NA/Other program
____Attended outpatient program _____Attended inpatient program _____Attended community-based program

LEGAL INFORMATION:

DO YOU HAVE A PROBATION OFFICER OR CASE WORKER? □ NO □ YES

IF YES, WHAT IS HIS/HER NAME?_____

PHONE NUMBER:_____

ADDRESS:_____

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorized Fresh Start Counseling Center to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize
(Name of insured)

_____(Name of Insurance Company)

To pay and hereby assign directly to Holly Johnson, LPC all benefits, if any, otherwise payable to me for her services as described on the attached forms. I understand that I am financially responsible for all charges incurred.

The doctrine of informed consents was explained to me and I understand that contents can be released. I understand the need for the information and that there are statutes and regulations protecting the confidentiality of authorized information. I further understand that once my Protected Health Information (PHI) is disclosed to the authorized individual/agency, there is potential for that PHI to be re-disclosed by the recipient and thus, no longer protected under the Privacy Act. I hereby acknowledge this consent is truly voluntary. I further acknowledge that I may revoke, in writing, this consent at any time except to the extent that action based on this consent has been taken.

_____ Client _____
Date

_____ _____
Witness Date

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

Privacy Practices at Fresh Start Counseling Center

Our Promise Regarding Medical Information

The confidentiality of your clinical records is important to us. We understand that your clinical information and disclosure is personal, and we are committed to protecting it. We create a file of the care and services you receive at Fresh Start Counseling Center, and we need this record to provide you with quality care as well as to comply with certain legal requirements. This notice will tell you about the ways we may use and share information about you. It will also describe your rights and the responsibilities we have regarding the use and disclosure of your clinical information.

Our Legal Duty

Law Requires Us To:

1. Keep your clinical information private.
2. Follow the terms of this notice.
3. Give you this notice describing our legal duties, privacy practices, and your rights regarding your clinical information.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are legal and ethical.
2. Make the changes in our privacy practices and the new terms of our notice effective for all clinical information on file, including information created or received before the changes went into effect.

Change to Privacy Practices:

Before we make an important change to our privacy practices, we will change this notice and make the new notice available.

Use and Disclosure of Your Medical Information

Attention: We will not use or disclose your clinical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by letting us know in writing.

For Treatment: If for any reason we need to disclose clinical information about you to doctors, nurses, or other people taking care of you, your counselor will ask you to sign a consent for release form. The release form will authorize your counselor's contact with the specified person and will explain the content which will be disclosed.

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

For Payment: We may use and disclose your clinical information for payment purposes. When a bill is sent to you or a third-party payer, the information on or accompanying the bill may include your clinical information.

For Health Care Operations: We may use and disclose your clinical information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees conducting training programs, and earning the accreditation, certificates, licenses, and credentials we need to serve you.

Notification: In case of emergency, we may use and disclose clinical information to notify or help notify: a family member, your personal representative, or another person responsible for your care. If you are present, we will get your permission if possible before we speak with them. If you are not able to give or refuse permission, we will share only the information that is directly necessary for your care, according to our professional judgment.

Court Orders and Judicial Administrative Proceedings: We may disclose clinical information in response to a court or administrative order, subpoena, discover request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your clinical information with law enforcement officials. We may disclose limited information with a law enforcement official concerning the clinical information of a suspect, fugitive, material witness, crime victim, or missing person.

Public Health Activities: As required by law, we may disclose your clinical information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose clinical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your clinical information if it is necessary to prevent a serious threat to the health and safety of you or others. We may share clinical information when necessary to help law enforcement officials capture a person who has escaped from legal custody or has admitted to being part of a crime.

Workers Compensation: We may disclose information when necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including insurance audits.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws, pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at

the request of a law enforcement official, and reporting death, crimes on our premises and crimes in emergencies.

Alternative and Additional Services: We may use and disclose clinical information o provide you with information about benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Your Individual Rights

You Have the Right to:

1. View or obtain copies of certain parts of your clinical information. You may request in writing that we provide copies in a format other than photo copies. We will use the format you request unless it is impractical for us to do so. You may ask for the form needed to request access. There will be charges for copying and for postage if you want the copies mailed to you. Ask about our fee structure.
2. Receive a list of all the times your counselor or other staff members shared your clinical information for purposes other than treatment, payment, and other specified exceptions.
3. Request that we change certain parts of your clinical information. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

Questions and Complaints

If you have any questions about this notice, please let us know. If you think that your privacy rights have been violated, are unable to resolve the issue with the therapist, and you wish to submit a written complaint to the U.S. Department of Health and Human Services, we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

The Rights of Clients

1. You have the right not to enter therapy. If you wish, I can provide you with the names of other therapists.
2. You have the right to end therapy at any time.
3. You have the right to ask any questions at any time about what we do during therapy and to receive answers that satisfy you.
4. You have the right to refuse the use of any therapy techniques, tests, or evaluations.
5. You have the right to keep what you tell me private. Limitations of confidentiality are discussed in my disclosure statement.

6. You have the right to deny any recordings of our counseling sessions. If I wish to record a session, I must first get your permission in writing.
7. You have the right to review your records in my files at any time as long as a professional is present to provide explanation of the information. You may also see the information shared with another professional as long as it does not violate someone else's right to privacy.
8. You have the right to know about my professional training and experience.
9. You have the right to discuss your therapy with anyone you choose, including another therapist.
10. You have a right to know all the terms of therapy, such as cost, appointment times, and privacy issues.
11. You have a right to read a copy of the therapist's guidelines or rules governing practice, such as the therapist's code of ethics.
12. You have the right to seek medical care if needed/desired.
13. You have the right to receive care regardless of your age or degree of disability.
14. You have the right to contact NC Disability Rights. Contact information is 877-235-4210 or email at info@disabilityrightsnc.org. NC Disability Rights, 3724 National Drive, Suite 100, Raleigh, NC 27612

The Benefits and Risk of Therapy

Research suggests that counseling can provide many benefits for its participants. As professional counselors, we at Fresh Start Counseling center are committed to providing competent counseling that is morally and ethically sound. It is out great desire that each client/couple/family/group reaches the goals of therapy we have set together. The reality is that we cannot guarantee that therapy will be successful. In fact, there are some inherent risks. In order to make an informed decision to enter a counseling relationship, each client/couple/family/group needs to consider both benefits and risks.

As with any powerful treatment, there are certain risks associated with counseling. For example, in the counseling process clients may experience uncomfortable levels of emotions such as sadness, guilt, anxiety, anger, frustration, or loneliness. Client problems may temporarily intensify at different stages of therapy or new symptoms may develop. A client's positive change is not always understood or viewed happily by family, friends, or associates. For example, therapy may disrupt a marital relationship. Counseling goals may not be resolved, or a client may not be any more self-aware than when therapy commenced. There are always risks associated with making important life decisions. As your therapist, I will be available to discuss any problems or negative side effects during our working relationship.

There are many reasons to be optimistic about counseling. Hundreds of well-designed research studies suggest that professional counseling provides opportunities for positive change. Studies support the helpfulness of counseling for dealing with depression, anxiety, bipolar disorder, grief and loss, sexual abuse, identity issues, relationship problems, family issues, and multiple categories of life skills. These are but a few of the many life circumstances for which counseling can be helpful.

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

Personal growth is exciting and is uniquely experienced by each individual. As long as cognitive abilities are intact, people have choices in life, even in the worst circumstances. We at Fresh Start Counseling Center believe that professional counseling provides optimal hope for change.

I will use my best clinical judgment when deciding whether I believe I can be helpful to you with your particular concerns. I have provided you with information that can help you make an informed decision about counseling. Therefore, if we enter a counseling contract, I will enter with optimism about the process.

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

May call to confirm/cancel appointments at: _____home _____work _____cell _____other

May **NOT** call: _____home _____ work _____ cell _____other

May correspond with billing, statements, and /or other business notices:

Home address:_____

Work address:_____

Other:_____

Print Name:_____

Signature:_____

Date:_____

CONSENT FOR TREATMENT

Psychological treatment has been proven to be effective in reducing personal and interpersonal problems, but may increase stress and worry before improving the emotional condition(s) or relationship(s). Given this caveat, I do _____, do not _____ authorize Holly Johnson and/or a member of Fresh Start Counseling Staff to provide psychological counseling and outpatient treatment for myself/minor's emotional condition.

_____ _____
Patient **OR** Parent/Guardian Signature Date

_____ _____
Witness Date

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____Child came without parent (Notice was sent to the parent via the mail)
_____Communications barriers prohibited obtaining the acknowledgment
_____Emergency situation prevented us from obtaining acknowledgement
_____Other (please specify) _____

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

PROFESSIONAL DISCLOSURE STATEMENT

Dr. Holly Johnson, LPC, NCC #8026
Fresh Start Counseling
512 E Fleming Drive
Morganton NC 28655
(828) 443-0005

EDUCATION
B.A. in Psychology, Regent University, 2006
M.A. in Professional Counseling, Liberty University, 2009
PhD. in Counselor Education and Supervision, Regent University, 2016

CREDENTIALS AND MEMBERSHIPS
Licensed Professional Counselor in the state of North Carolina, #8026
Nationally Certified Counselor, #305432
Member, Licensed Professional Counselor Association of NC
Member, American Psychological Association

EXPERIENCE
Lay Counselor, 16 years
TLC Counseling Center, Morganton, NC, 2 years
Caring Alternative, Morganton, NC, 2 years
Fresh Start Counseling Center, Morganton NC, since August 2009

COUNSELING PRACTICE
Counseling services are provided to individuals and couples, youth and adults, in the areas of bereavement, depression/anxiety, addictions, life transitions, and personal and/or spiritual growth. My training is in professional counseling with an additional specialization in issues of spirituality or faith. My areas of experience include: personal growth, addictions, anxiety and depression, inner healing and trauma, grief and bereavement, sex abuse/sex offender treatment, stress and burnout, and life and career transitions. In the counseling process, clients can be helped to understand themselves better, set personal goals, and be supported in the process of working toward those goals. If the client and/or counselor decide this counseling practice is not appropriate for the client's needs, the client will receive assistance in contacting an appropriate referral source which can better meet their needs.

Most clients can expect to benefit from counseling, making positive changes in their thoughts, feelings, behaviors, and styles of coping. Some, however, may not find counseling profitable. Efforts to change self-perception, emotions, and behaviors require work both in session and out of session. Some change will occur quickly and easily, but more often change requires slow, deliberate, and repeated efforts. Even the most successful counseling and therapy may at times be painful or distressing, as the client deals with emotionally difficult issues.

My theoretical style is a blend of cognitive-behavioral, reality, family systems, and person centered therapy depending on the needs of the client. Techniques include individual counseling (talk therapy), assessment and interpretation of assessments, provision of appropriate information and facilitation of decision making, and goal setting. Most sessions will focus on self-awareness, problem solving, choices, and goal setting for both the present and the future. Other areas of counseling may include focusing on meaning of life, strengths and limitations, acceptance, responsibility, self-concept, and change. Treatment is based upon the needs of the individual, couple, or family. In addition, homework exercises may be given as needed.

I believe that maintaining a trusting working relationship between counselor and client is vital, and I strive to achieve that collaboration. I am comfortable working with individuals from diverse cultures and lifestyles and feel being accepting,

respectful, objective, and genuine are characteristics that are essential in working with clients. Overall, counseling is a process in which you the individual gains knowledge and tools that will facilitate continued growth and development after therapy has ended.

LENGTH OF SESSIONS
Sessions are 45-60 minutes in duration. We will schedule our sessions for our mutual agreement. If you are unable to keep an appointment, please call the office to cancel or reschedule **at least 24 hours in advance.**

It is impossible to guarantee any specific results regarding your counseling goals because the outcome is dependent on your work as well as mine. Together, however, we will work to achieve the best possible results. Referral to another counselor or service will be mutually discussed if progress is not achieved at a satisfactory level or in the event that additional services may be in your best interest.

COUNSELING FEES
Fees are $135 for a 45-60 minute session or $185 for the initial intake session.
Cash, personal checks, or credit cards are acceptable for payment at the time services are rendered. I can accept some insurance plans such as United Behavioral Health, Blue Cross Blue Shield of N.C., MedCost, Medicaid, NC Healthchoice, Aetna, and Tricare. You will be responsible for deductibles and co-payments according to your insurance plan at the time services are rendered. Claims will be filed by my office.
I do offer a sliding scale fee for the uninsured and based upon need. The fee scale is $60-$185.

NOTE: A 24 hour notice must be given for cancellations or you may be billed for the full amount. Please understand that missed appointments cannot be billed to insurance.

AS YOUR COUNSELOR:
1. *Informed Consent:* I will inform you of the purposes, goals, techniques, and procedures under which you may receive counseling. Prior to assessment, I will explain the nature and purposes of assessment tools and the specific use of results. Results will become part of the client's record.

2. *Confidentiality:* I will protect the confidentiality of information received in our counseling relationship as specified by federal and state laws, written policies and ethical standards. For any of the following matters, legally and ethically, I may break confidentiality and involve others who can help:

A. If mandated by a court of law:
B. if disclosure is required to prevent clear and imminent danger to yourself and/or others:
C. if I am made aware of the potential or actual occurrence(s) of physical/sexual abuse of minors, persons with disabilities or senior citizens;
D. I will disclose information to an identified third party who is at high risk of contracting a disease from you that is both communicable and fatal, providing that you have not already informed him/her or are not intending to do so.

3. *DSM-V* (*Diagnostic and Statistical Manual*) diagnoses are used, and become part of the individual's file.

IN CASE OF EMERGENCY
If you have an urgent situation that you feel needs immediate support and I am not available in my office or by phone, please contact one of the following: your primary care physician, go to the nearest hospital emergency room, or call 911.

Fresh Start Counseling Center

512 E. Fleming Drive, Morganton, N.C. 28655 Phone: 828-443-0005 Fax: 888-972-4799
Dr. Holly C. Johnson, LPC, NCC #8026

CONCERNS REGARDING LICENSURE

If you are dissatisfied with any aspect of the counseling process, please inform me so we can determine if our work together can be more efficient and effective or whether referral would be appropriate. If you think I have treated you unfairly or unethically, and we cannot resolve the problem, contact:

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblpc.org

ACKNOWLEDGEMENT

I have read the above in its entirety. I am informed about the policy regarding confidentiality of information. I may provide during counseling and the limits of that confidentiality. With full understanding of these provisions, I give my informed consent to receive counseling services.

Signed_____Date_____
(Client)

Signed_____Date_____
(Client)

Signed_____(Counselor)