MAY AND ASSOCIATES THERAPY CENTER
862 BRAWLEY SCHOOL RD SUITE 202
MOORESVILLE, NC 28117
WELCOME!

DATE_____ THERAPIST_____

DESIGNATED
CLIENTS NAME _____
LAST FIRST MIDDLE

HOME ADDRESS _____
STREET PO CITY STETE ZIP

BIRTHDATE _____ AGE _____ CELL PHONE ( ) _____

HOME PHONE ( ) _____ WORK PHONE ( ) _____

EMAIL _____

SS# _____GENDER M F MARITAL STATUS: S M D W SEP

EDUCATION COMPLETED _____ OCCUPATION _____

EMPLOYER OR SCHOOL ATTENDED _____
(circle one)
SPOUSE OR PARENTS NAME _____ DOB _____
(circle one)

RELATIVE TO NOTIFY IN CASE OF EMERGENCY _____

RELATIONSHIP_____ PHONE # ( ) _____

INSURANCE
POLICY HOLDER NAME _____

ADDRESS _____

DOB _____PHONE# _____SS#_____

EMPLOYER _____

RELATIONSHIP TO CLIENT _____

INSURANCE COMPANY_____ID#_____

GROUP# _____ INSURANCE CO. PHONE #_____

PLEASE LIST EVERYONE WHO LIVES IN YOUR HOME WITH CLIENT:

NAME RELATIONSHIP NAME RELATIONSHIP

_____

_____

Has the client been involved in therapy or any other type of counseling programs?

If so, When _____ Where_____

Reason_____

Is the client presently under a physician's care for physical problems _____Yes _____ No

Primary Care Physician_____ Phone ( ) _____

List Allergies, if any _____

Current Medications

_____

_____

Substance Abuse History : Type _____Date(s)_____

_____ _____

What problems are you presently experiencing?_____

_____

What do you expect from therapy? _____

_____

If need be, would other relatives be willing to come into therapy sessions?

_____Yes _____No If no, please indicate reason_____

All professional services rendered are charged to the client. Necessary forms will be completed to expedite insurance carrier payments. The client is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

I hereby authorize May and Associate Therapy Center to furnish information to insurance carriers and referring physicians concerning my treatment and I hereby assign to the provider all payments for professional service rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE_____DATE_____

PATIENT RIGHTS AND RESPONSIBILITIES
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Confidentiality

Privacy and confidentiality are of the utmost importance to the clinical relationship. The therapist will not share information with any person without your written permission, except as required by law, your insurance company or in a situation deemed potentially life threatening.

Cultural Competency

Administrative staff and all clerical personnel accept the core importance of treating all persons with respect for their personal worth and value. We are committed to protecting public health, safety and welfare. We do not discriminate against clients or professionals based on race, religion, age, gender, handicaps, national ancestry, sexual orientation, or economic conditions. We endorse all federal and state laws that ensure all persons are treated equally

Appointments

Appointments are scheduled as a fifty five minute therapeutic hour. As a courtesy to you, our office does not "double book" clients for the same time slot – you have a specific appointment reserved just for you It is very important that you handle any cancellations properly. In the event that you must cancel an appointment, please call the office at 704-659-4707 at least 24 hours in advance. FAILURE TO GIVE ADEQUATE NOTICE CAN RESULT IN YOUR BEING BILLED FOR THE APPOINTMENT. Insurance does not cover missed or cancelled appointments. We have a voice mail system should you need to call after business hours to cancel an appointment.

Please note that not showing for a scheduled appointment will result in any future appointments being cancelled. You will need to call the office to reschedule and any resultant fees. Excessive late cancellations and "no show" appointments can result in discontinuation of services with our office.

Billing and Insurance

You are responsible for providing current and accurate insurance information. Our office will file insurance claims as a courtesy to you unless you indicate otherwise. You are responsible for the payment of all applicable fees at the time of service. Our filing of an insurance claim does not relieve you of your responsibility for the account. The office does not become involved with division of accounts between divorced parents. We accept payment by cash, personal check, Visa, Mastercard, or Discover.

You are responsible to know and understand the terms of your health contract benefits. For information regarding your insurance coverage, please call your insurance company directly. We will make every attempt to find out from your insurance company if they require pre-authorization and/or case management. IT IS HOWEVER, WISE FOR YOU TO LEARN FROM YOUR INSURANCE CARRIER IF THESE TYPES OF REQUIREMENTS EXIST SINCE YOUR CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY. If your insurance fails to pay on a timely basis (45 days), we will send you a statement of account notifying you that your claim is unpaid, at which time, you must assist in pursuing your benefits. Under some managed care plans, the therapist is required to provide clinical information to a case manager after the initial session if additional sessions are needed. If you have any questions about this procedure, please feel free to discuss this with the therapist.

Signature: _____ Date: _____

Signature: _____ Date: _____

Medicaid ID # _____ DOB _____

PATIENT RIGHTS AND RESPONSIBILITIES
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Acknowledgement of receipt of Notice of Privacy Practices

I understand that all client conversations and records will be kept confidential unless written permission is granted otherwise. However, state law requires that therapists report any suspected child abuse or any concerns that s/he may have regarding a patient's possible likelihood of harming him/herself or others. I grant permission to the therapist to communicate with my emergency contact person if a situation is deemed potentially life-threatening.

If it becomes necessary to turn your account over to a collection agency, some confidentiality will be disclosed for collection purposes.

I understand that May and Associates Therapy Center follows the guidelines set by the Health Information Portability and Accountability Act (HIPPA). I understand I can request a printed copy of these guidelines. If you feel your HIPAA rights have been violated, you may file a complaint with our privacy officer, your LME if Medicaid, or the professional board listed on your therapist's professional disclosure statement.

Acknowledgement of receipt of Disability Rights

I have read and understand my disability rights in North Carolina posted. I understand I can request a printed copy of these guidelines.

Patient Records

Patient records at May and Associates Therapy Center are accessed only by your providing therapist and the office staff.

Waiver of Subpoena Records/Clinician

I understand that I am waiving all rights to subpoena records or verbal reports of the psychotherapy provided by any May and Associates Therapy Center therapists. My signature represents my agreement that therapy is for the purpose of healing and will not be used to harm or disrespect anyone who might be included in the treatment.

Miscellaneous Fees and Charges

A collections fee of 40% of your account balance will be added to your past due account if we are unable to obtain payment. A service charge of $25 will be applied to all returned checks.

Insurance

I authorize May and Associates Therapy Center to furnish information to insurance carriers and referring physicians concerning my treatment and assign to the provider all payments for professional service rendered to yourself and your dependents.

Consent to Treatment

I have read and understand the above information. I acknowledge and agree that May and Associates Therapy Center and affiliates will have no liability for any matters related to the counseling sessions. I give full consent for therapeutic services.

Signature: _____ Date: _____

Signature: _____ Date: _____

Medicaid ID # _____ DOB _____

Professional Disclosure Statement

This professional disclosure statement is designed to inform you about my background, counseling orientation and to ensure that you understand our professional relationship.

PERSONAL:

I, Perri C May, LMFT earned my MA in Counseling from Pfeiffer University. I have worked with children, adolescents and adults, in private practice, the school system, hospital setting and clinical behavioral health. I am currently a licensed Marriage and Family Therapist (LMFT). I am also presently certified in Prepare/Enrich .

PHILOSPHY;

I believe counseling begins with an understanding of clients as whole beings with physical, mental, spiritual and emotional aspects all interacting. Through my studies and experience I have adopted a repertoire of psychoanalytical theories which I utilize based on your needs and communication style. My goal is not to have you fit into a psychoanalytical theory but instead to be able to utilize the theory that will best empower you in your life situation. I find that understanding patterns in behavior, origins of behavior, accepting responsibility for past, current and future behavior, forgiveness, and learning approaches to help in the formation of healthy relationships to be important aspects in therapy.

Counseling requires your active participation. My role as a therapist is to help you identify areas of concern and goals, investigate with you the causes and origins of behaviors that may maintain unhealthy patterns, teach coping skills when applicable, supply tools to assist in identity development, and suggest strategies to help you reach your goals and develop healthy patterns. My role as a therapist is not to tell you what to do but instead to provide counsel to help empower you to understand and make your own choices and take responsibility for your decisions.

CONFIDENTIALITY:

The counseling sessions are kept confidential and client information will not be disclosed to anyone except in the following circumstances:

1. If the counselor feels you are about to do harm to yourself or someone else, they must, by law, take steps to protect the vulnerable party. Any suspected abuse of a minor, the elderly, or the handicapped must also be reported.
2. If the client is a minor, the counselor must inform the parent or guardian of the counseling procedures. However, the privacy of the actual details of the individual sessions remains confidential between client and counselor.
3. If the counselor feels it would be in the client's best interest for the counselor to consult with counseling supervisors or colleagues, they reserve this right while protecting your identity
4. If the therapist is subpoenaed by the court to submit the case notes for trial purposes (such as custody hearing or other legal issues involving the client), the counselor is legally bound to submit the requested materials.

EXPLANATION OF DUAL RELATIONSHIPS:

It is important to recognize that the relationship between the counselor and client is professional in nature, It is common to feel a connectedness to someone when sharing intimate concerns, however, boundaries need to remain intact.

LENGTH OF SESSIONS AND PAYMENT:

Sessions are 50 minutes in length. If you are unable to keep an appointment, please call to cancel or reschedule at least 24 hours in advance.

Counselors at May and Associates Therapy Center charge $125 a session. Our offices will file insurance claims as a courtesy to you unless you indicate otherwise. You are responsible for providing current and accurate insurance information, for the payment of all deductible and co-payment amounts, as well as all applicable fees, at the time of service. A record of payment is available if you want to file your own insurance claim.

The length of treatment is relative to the severity of the case and the depth the client wishes to go. At the beginning of counseling it is advisable to approach it on a trial basis, committing to an initial four sessions for mutual evaluation.

If you have any comments regarding treatment received from me, please do not hesitate to contact Perry C May at May and Associates Therapy Center, 862 Brawley School Road, Suite 202, Mooresville, NC 28117 704-659-4707, Partners Behavioral Health at 901 S. Hope Rd, Gastonia, NC 28054, or the North Carolina Marriage and Family Therapy Licensure Board at PO Box 37669, Raleigh,,NC 27627.

Consent to Treatment:

I, the undersigned, having read and asked the counselor for any needed clarification of the procedures and conditions mentioned in this document, understand the above information and I am in agreement with the noted conditions for treatment. I acknowledge and agree that May and Associates Therapy Center and affiliates will have no liability for any matters related to the counseling sessions. I give full consent for therapeutic services to be provided by Perri C May, LMFT for:

_____ Date: _____

Name of Client (please print)

_____ Date: _____

Signature of Client

_____ Date: _____

Signature of Responsible Party (if different)

I have reviewed the document with the client and believe the client has full understanding of the document and my explanations, and has been given the opportunity to ask for further clarification.

_____ Date: _____

Signature of Counselor