



Joe Rabiaga, MA, LPC
8300 Health Park, Suite 201
Raleigh, NC 27615
919-676-9699 x 3
www.CarolinaPerformance.net

New Client Intake Form

First Name: _____ **Middle Name:** _____ **Last Name:** _____ **Date:** _____

Mailing Address: _____

Physical Address (if different): _____

May I send mail to the above address? **Y / N**

Telephone Numbers (Please provide only numbers at which you give me permission to call you):

Home: _____ May leave a detailed message? ___yes ___no

Work: _____ May leave a detailed message? ___yes ___no

Cell: _____ May leave a detailed message? ___yes ___no

Email address: (Provide only if it is OK to send you an email. Please note that the confidentiality of email communications can't be guaranteed): _____

Date of Birth and Age: _____

Relationship Status: _____

Occupation/Grade Level and School if Minor: _____

Have you ever engaged in therapy before? Y / N If yes, please briefly describe: _____

Have you ever worked with a psychiatrist? Y / N If you currently have a psychiatrist, please provide name/phone number: _____

Are you currently experiencing thoughts of wanting to harm yourself? Y / N If yes, please briefly describe: _____

Emergency Contact: _____ **Telephone #:** _____ **Relationship to You:** _____

Primary Care Physician: _____ **Telephone#:** _____

Medical Problems: _____

Current medications/dosages (Psychiatric and non-psychiatric): _____

Medication Allergies: _____

Hospitalizations (Medical, Psychiatric, Substance abuse- please give reason, place and year): _____

Family history of:

Mental illness? _____ Yes _____ No

Substance abuse? _____ Yes _____ No

Suicide? _____ Yes _____ No

Violent behavior? _____ Yes _____ No

If yes to any of the above questions, please describe: _____

List the members of your family and all others in the home:

| Name | Age | Relationship to child | Occupation/Grade |
|------|-----|-----------------------|------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

FOR MINORS CLIENTS ONLY

List birth parents, stepparents, siblings, or step siblings who are not living in the home:

| Name | Age | Relationship to child | Occupation/Grade |
|------|-----|-----------------------|------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

How often do you currently:

Smoke: _____ never _____ monthly _____ weekly _____ daily

Drink alcohol: _____ never _____ monthly _____ weekly _____ daily

Use illegal drugs: _____ never _____ monthly _____ weekly _____ daily

Exercise: _____ never _____ monthly _____ weekly _____ daily

Primary Insurance:

Insurance Plan Name: _____

Insurance Plan Address and Phone Number: _____

Insured Name: _____ Insured ID#: _____ Insured DOB: _____

Insured's Social Security #: _____ Copayment or deductible: _____

How did you hear about my services? _____

If referred, name of provider or practice: _____

Reason(s) for seeking therapy? (Please be specific, for example: depression, anxiety, relationship issues, etc.)

What would you like to gain from working with me? What are your goals (if not sure, then leave blank)?



Joe Rabiega, MA, LPC
Licensed Professional Counselor
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INFORMED CONSENT AND INFORMATION FORM FOR COUNSELING SERVICES

ABOUT CAROLINA PERFORMANCE

We are a group of independently operating psychiatrists, psychologists, counselors, and sport psychology consultants that offer integrated mental health services. We work together as a group for the purpose of sharing office space and necessary support and equipment to facilitate our ability to practice our professions independently. At times, we may consult with one another for the purpose of treatment coordination and routine peer supervision. If I need to consult with another clinician, I will make every effort to not provide any identifiable information about you. In other words, I will keep you anonymous. We operate under a single name (“Carolina Performance”) for ease of recognition. However, we are not otherwise bound to one another, e.g., no shared malpractice insurance.

ABOUT COUNSELING

Counseling or psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and the client, and the particular concerns you are experiencing. There are many different methods that I may use to deal with the concerns that you hope to address. Psychotherapy calls for an active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and in everyday life situations.

Psychotherapy can have benefits and risks. Since therapy may involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There is no guarantee that you will personally benefit from counseling and as described above, participating in counseling involves some risks.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my approach, we should discuss them whenever they arise. If your doubts persist, I would be happy to help you set up a meeting with another mental health professional for a second opinion.

SUMMARY OF MY PROFESSIONAL EXPERIENCE

- Over 7 years of providing mental health services in the following areas: Outpatient, hospital, school, community and home-based counseling to children, adolescents, adults and families. I have experience with various mental health disorders/problems including: depression, anxiety, trauma, bipolar disorder, behavior management issues, family discord and psychosis.
- Skilled in conducting initial mental health assessments and collaborating with other mental health/medical professionals to determine appropriate treatment.
- Extensive experience working with clients in crisis including: conducting suicide assessments and safety planning.

MY APPROACH TO COUNSELING

I believe in an individualized treatment plan that focuses on the unique characteristics and strengths of the person, their situation and environment. When collaborating with clients on their goals for treatment, I take into account physical, social and emotional stressors, including past experiences. My therapeutic approach involves the various methods/techniques including:

- a) Providing a non-judgmental atmosphere that encourages personal growth through empathic listening, respect and genuine concern for my client's well-being.
- b) Helping clients better understand and/or find a solution to their problem(s).
- c) Exploring past relationships and difficult times to better understand their impact on the present.

I will sometimes take notes during our sessions so that I may review them later. Please know that you always have my full attention even if I should be taking notes. Being able to review session notes helps me to understand your problem(s)/concern(s) and to develop an effective treatment plan.

WHAT TO EXPECT FROM OUR RELATIONSHIP

I am licensed and trained to practice counseling—not law, medicine, or any other profession. I am not able to give you good advice from these other professional viewpoints. Also, state and federal laws and the ethics of my profession require me to keep what you tell me confidential (that is, private). It is your decision to tell others about the work we are doing together. You can trust me not to tell anyone else what you tell me, except in certain limited situations, explained below. If we meet on the street or socially, I may not say hello or talk to you very much. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually available between 9AM and 5PM, I will not answer the phone when I am with a client. My telephone is answered by a voicemail that I monitor frequently. You may call my voicemail 24 hours a day and leave a message 919-676-9699 x 3. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. **Please do not leave phone numbers for me to return your call if you would not want me to identify myself to someone who answered the phone (family member, roommate, etc.).** When leaving a message I will only state my name and ask you to return my call. I will not identify myself as a counselor.

CLIENT RESPONSIBILITIES

1. To arrive on time for your appointment and to provide me with at least 24 hours notice of the need to cancel/reschedule.
2. Therapy is an interactive and dynamic process between the client and the counselor; therefore, your active participation is essential for the process to be successful.
3. If you are troubled at any time about the way therapy is progressing, it is essential that you inform me of this so that we can ensure that you are receiving the best care possible.
4. Please inform me at any time if you are experiencing thoughts of wanting to harm yourself or someone else. Please see the emergencies section below if these thoughts come about and I am not immediately available.

PAYMENTS, INSURANCE AND FEES

You will be expected to pay for each session at the time it is held. I am considered an in-network provider with many health insurance panels, therefore, if you are using your in-network benefits with the insurance panels I am on, you may only have a copayment. I will make every effort to verify your benefits and your financial responsibility prior to the first

appointment; however, you are ultimately responsible for verifying your insurance coverage and payment of the session fee(s).

If you are using your out of network benefits for insurance panels I am not on, my fee is to be paid upfront at each session and it is the client's responsibility to submit a claim to their insurance company based on their out of network benefits procedures. I will provide each client with a receipt for each session which will include the necessary information to file an insurance claim. I will also work with clients and their insurance companies if needed to help with reimbursement. Please note that insurance companies usually require a DSM-IV-TR (mental health) diagnosis and other clinical information from our sessions. The diagnosis will become a part of the client's medical record.

My session fees are:

1. \$130.00 for the initial intake session (60 minutes)
2. \$100.00 for 45-50 minute individual counseling sessions
3. \$50.00 for 30 minute individual counseling sessions

APPOINTMENT CANCELLATION AND LATE ARRIVALS

Once an appointment is scheduled, **you will be expected to pay for it unless you provide 24 hours advance notice of cancellation** (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions. And since clients are seen by appointment, if you arrive late, the appointment must end as scheduled and you will be charged for the full amount of your scheduled visit. This will allow me to see each client when they are scheduled.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a counselor is protected by law, and I can only release information about our work to others with your written permission. When working with clients under the age of 18, the conversations between the therapist and client (minor child) will be kept private unless there is a concern for the client's well-being that the parent needs to know about OR if the client chooses to share this information with the parent.

Client records will be kept secure and will only be accessible to the counselor. There are also some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, an elderly person, or disabled person is being abused, I must file a report with the appropriate local or state agency. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I am obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. In rare cases, I may also be ordered by court to release confidential or privileged information. If such a situation occurs, I will make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I will make every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential.

EMERGENCIES

If you are unable to reach me and feel that you can't wait for me to return your call, you may:

1. Contact another treating Carolina Performance provider if you have one.
2. Contact another mental health provider, i.e., psychiatrist if you have one.
3. Contact your family physician.
4. Call the Hopeline at (919) 231-4525 or the Holly Hill Hospital Respond Line at (919) 250-7000.
5. Go to the nearest emergency room or in the event of a life-threatening emergency call 911.

*If you experience an emergency and are unable to contact me, please notify me as soon as possible as to the outcome.

ACCESS TO RECORDS

As described in the HIPAA privacy notice, you have a right to review your medical records. There may be times when providing full access to your records would potentially cause harm due to your current emotional state or a misunderstanding of the terminology and/or information. If I feel this is the case, I will provide you with a summary of what is in your record. If at any time, I should become unable to provide counseling services (e.g., extended illness or death), please contact Dr. Eric Morse at Carolina Performance for information on how to access your records.

CONSENT FOR TREATMENT

Your signature below indicates that you have read this Informed Consent and Information Form and agree to its terms, had the opportunity to review the HIPAA Notice of Privacy Practices, reviewed/received a copy of my Professional Disclosure Statement and had any questions you might have answered. Now or at any time during treatment, please feel free to ask questions about any of the information you have read or about the course of your treatment.

Signature of Client

Date

Signature of Parent/Guardian of Minor Client

Date

Printed Name of Client

Therapist Signature

INSURANCE COMPANY RECORD RELEASE AUTHORIZATION

I hereby authorize Joe Rabioga, MA, LPC to provide information including but not limited to a mental health DSM-IV diagnosis to insurance companies concerning my illness/treatment.

Signature of Client

Date

Signature of Parent/Guardian of Minor Client

Date

I, the counselor, have met with this client for a suitable period of time, and have informed him or her of the issues and points raised in this document, the HIPAA Notice of Privacy Practices form, and my Professional Disclosure Statement. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into counseling with the client, as shown by my signature here.

Signature of counselor

Date

PAYMENT FOR LATE CANCELLATION OR NO-SHOW

I authorize Joseph Rabiega, MA, LPC to bill the credit card below when I do not give at least 24 hours advanced notice for cancelling an appointment or I no-show for my appointment. Emergencies which do not allow for advanced notice of cancellation or no-shows will be taken into consideration when charging for missed appointments. I understand that if I do not wish for my credit card to be billed for this purpose, I am still responsible for paying these fees.

Signature

Date

CREDIT CARD PAYMENT FOR PROFESSIONAL SERVICES

___ VISA ___ Mastercard

Name on Account (exactly as it appears on credit card)

Address (ONLY if different from the intake form)

City

State

ZIP Code

Credit Card Number

Exp. Date

3 Digit Security Code (on the back of the card)

I authorize Joseph Rabiega, MA, LPC to bill the above credit card for professional services.

Signature

Date

Joe Rabiaga, MA, LPC
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Professional Disclosure Statement

1. Education- Master of Arts in Psychology, 2001, Marywood University
2. Licensure- Licensed Professional Counselor (LPC) #8195 in North Carolina.
3. Member- Licensed Professional Counselors Association of North Carolina (LPCANC)
4. I have over 7 years of counseling or counseling-related experience.
5. I have experience providing counseling and assessment services to children, adolescents, adults and families with various mental health and substance abuse problems in outpatient, home, school, community, hospital and residential-based settings. Treatment has included a variety of therapeutic approaches including cognitive-behavioral therapy, insight-oriented therapy, supportive counseling and crisis counseling.
6. I provide a multi-theory approach to counseling that is based on the needs of each individual client. First and foremost, I believe that the counselor and client relationship is paramount in the counseling process. Counseling approaches I use include cognitive-behavioral therapy which is used to bring about symptom or behavior changes through a variety of cognitive and/or behavioral techniques. Insight-oriented treatment may also be used in cases where understanding the root of a problem is necessary to overcome the current problem(s) the client is facing. I utilize an individualized approach when assessing, developing treatment goals and providing counseling. More about my approach and the counselor-client relationship/responsibilities will be described in the Information/Informed Consent document.
7. The first session will include an assessment of the presenting problem(s) and reasons for seeking counseling. This session will last approximately 1 hour and the fee charged will be \$130.00. Subsequent sessions will be approximately 45-50 minutes and the fee charged will be \$100.00. 30 minute sessions will be \$50.00.
8. Cash, personal checks, credit cards (Visa and MasterCard) will be acceptable forms of payment.
9. I am considered an in-network provider for most insurance panels, and I will file the insurance claims for you. For insurance panels I am not on, my fee is to be paid upfront at each session and it is the client's responsibility to submit a claim to their insurance company based on their out of network benefit procedures. I will provide each client with a receipt for each session which will include the necessary information to file an insurance claim. I will also work with clients and their insurance companies if needed to help with reimbursement. In some instances, I may be able to provide a reduced fee for clients without insurance. Specific fee arrangements in these situations will be discussed prior to the start of counseling.
10. A mental health (DSM-IV-TR) diagnosis will be used to establish treatment goals and it may also be needed for insurance purposes. The diagnosis will become a part of the client's medical record.
11. All therapeutic services that I provide are confidential and the information discussed between me and the client will be kept private unless the client provides authorization for me to consult with others, for example, their medical doctor, other mental health providers, insurance company, etc. I may be required to release information without prior authorization in the following circumstances: a) a person is in danger of harming themselves, b) a person is threatening to harm someone else, c) suspected child or elder abuse is reported, or d) if the records are ordered by a judge to be turned over. If I need to provide confidential information in any of these circumstances I will limit the information I provide and also attempt to inform the client of what information is being provided.
12. Complaints against this counselor can be made via the North Carolina Board of Licensed Professional Counselors:
P. O. Box 1369
Garner, NC 27529
Phone: (919) 661-0820 <http://www.ncblpc.org/index.html>

By signing this statement you are acknowledging that you have read it and have had an opportunity to have any questions answered to your satisfaction.

Client Signature: _____ Date: _____
Counselor Signature: _____

PLEASE READ CAREFULLY AND KEEP- YOU DO NOT NEED TO RETURN THIS FORM TO ME!

Joe Rabiaga, MA, LPC
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NOTICE OF PRIVACY PRACTICES

I am required by law to follow the procedures outlined in this policy and to protect the privacy of your protected health information (PHI). This notice describes how mental health and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You will be provided with a copy of this notice and you can request a copy of the notice at any time. This notice was created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Effective Date of this Notice: December 7, 2010. Please ask me to explain anything you do not understand in this document.

What is meant by the phrase, “mental health and medical information?”

Each time you visit me or any doctor’s office or hospital, clinic information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests and treatment you got from me or from others, or about payment for health care. The information I collect from you is called “PHI,” which stands for “protected health information.” This information goes into your medical or health care records in my office.

A. I may use and disclose your protected health information (PHI) in the following ways:

1. I may use and disclose PHI about you to provide health care treatment.

I may use and disclose PHI about you to provide, coordinate or manage your health care and related services. For example, I may use or disclose your PHI when you need a referral for other health care services, such as a physician, psychiatrist, nutrition specialist, or another therapist.

2. I may use and disclose PHI about you to obtain payment for services.

Generally, I may use and disclose your PHI to others in order to bill and collect payment for the services you receive from me. For example, I may contact your health insurer before you receive services to assure that my services are covered, and to certify what mental health benefits you are eligible for. I may provide your insurer with details regarding your treatment including mental health diagnosis to determine if your insurer will cover, or pay for, your treatment

3. I may use and disclose PHI about you for health care operations.

I may use and disclose PHI about you in performing business activities, which we call “health care operations.” These health care operations allow us to improve the quality, efficiency, and costs of the services provided to you. Examples of the way I may use and disclose information about you for health care operations include the following:

- Reviewing and improving the quality, efficiency, and cost of care that I provide.
- Cooperating with outside organizations that assess the quality of the care I and others provide. For example, the NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services.
- Assisting various people who review my activities. For example, PHI may be seen by doctors, and by accountants, lawyers, and others who assist me in complying with applicable laws.
- Conducting business management and general administrative activities related to our organization.
- Resolving grievances within our organization.
- Complying with this notice and with applicable laws.

4. I may use and disclose PHI about you under other special circumstances.

I may use and disclose PHI about you under the following circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object:

- When the use and/or disclosure is required by law. For example, when a disclosure is required by federal, state or local law, or other judicial or administrative proceedings such as in response to an order of a court.
- When the disclosure relates to victims of abuse, neglect or domestic violence. For example, if you give me information which leads me to suspect child abuse, neglect, or death due to maltreatment, I must report such information to the county Department of Social Services.
- When the use and/or disclosure is for healthcare oversight activities. For example, I may disclose PHI about you to a state or federal healthcare oversight agency which is authorized by law to oversee our operations.
- When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure is for law enforcement purposes. For example, I may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure is to avert a serious threat to health or safety. For example, I may disclose PHI about you to prevent or lessen a serious and imminent threat to the health or safety of you or a person in the public. This may include notifying the person you list to contact in case of an emergency or someone such as a relative that is involved in your treatment.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, I may disclose PHI about you to a correctional institution having lawful custody of you.
- Worker's Compensation: If you file a worker's compensation claim, I am required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.

5. I may contact you to provide appointment reminders.

I may use and/or disclose PHI to contact you to provide a reminder to you about an appointment you have.

**** ANY OTHER USE OR DISCLOSURE OF PHI REQUIRES YOUR WRITTEN AUTHORIZATION ****

Under any circumstances other than those listed above, I will ask for your written authorization before I use or disclose PHI about you. If you sign a written authorization allowing me to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, I will not disclose PHI about you after I receive your cancellation, except for disclosures which were being processed before I received your cancellation.

B. Your Rights Regarding Your Protected Health Information (PHI)

1. You have the right to request confidential communications. You have the right to request that I communicate with you about your health and related issues in a particular manner or at a certain location. I will accommodate reasonable requests.

2. You have the right to request restrictions on the uses and disclosures of PHI about you. You have the right to request a restriction in my use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request; however, if we do agree, I am bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in my use or disclosure of your PHI, you must make your request in writing.

3. You have the right to see and receive a copy of PHI about you.

You have the right to inspect and obtain a copy of the PHI contained in clinical and billing records. You must submit your request in writing in order to inspect and/or obtain a copy of your PHI. I may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Instead of providing you with a full copy of the PHI, I may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary

or explanation. There are certain situations in which I am not required to comply with your request. Under these circumstances, I will respond to you in writing, stating why I will not grant your request and describing any rights you may have to request a review of my denial.

4. You have the right to request amendment or changes to PHI about you.

You may ask me to amend your health information if you believe it is incorrect or incomplete. Your request must be made in writing and must provide me with a reason that supports your request for amendment. I may deny your request if: a) you fail to submit your request (and the reason supporting your request) in writing; b) the information in my opinion is accurate and complete; c) not part of the PHI kept by or for or created by this practice; or d) not part of the PHI which you would be permitted to inspect and copy as described in paragraph 3 above. I will tell you in writing the reasons for the denial and describe your rights regarding a statement disagreeing with the denial. If I accept your request to amend the information, I will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment.

5. You have the right to request a written listing of disclosures.

You may ask in writing, for an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures my practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of routine client care is not required to be documented. An example of a routine sharing of information would be disclosures to billing services, for health care operations, as authorized by you, or allowed or required by law. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but I may charge you for additional lists within the same 12-month period. I will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. You have the right to a paper copy of this notice.

You are entitled to receive a paper copy of this Notice of Privacy Practices.

7. You have the right to file a complaint.

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Office of Civil Rights
US Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

8. You have the right to request restrictions on uses and disclosures.

I will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide me regarding the use and disclosure of your PHI may be revoked by you at any time in writing. After you revoke your authorization, I will no longer use or disclose your PHI for the reasons described in the authorization.