Ebony Counseling Consulting and Supervision

REGISTRATION FORM

4300 B Street Ste 410
Anchorage, AK
99503
907-602-0305

Today's Date:					
CLIENT INFORMATION					
Client's last name: [Last Name]	First: [First Name]	Middle: [Initial]	Marital status:		
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
ADDRESS					
Social Security no.:	Home phone no.:	Cell phone no.:			
Occupation:	Employer:	Employer phone no.:			
Chose clinic because/referred to clinic by ○ _____					
Other family members seen here:					
INSURANCE INFORMATION (Please Provide a Copy of Your Card)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a client here?	○ Yes ○ No	Is this client covered by insurance?	○ Yes ○ No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
Client's relationship to subscriber:					

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Client's relationship to subscriber:			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Client:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Ebony Counseling Consulting and Supervision or insurance company to release any information required to process my claims.

Client/Guardian signature

Date

Ebony McClain, Ph.D.
Licensed Professional Counselor
4300 B Street Ste 410 Anchorage AK, 99503
ebonycounseling@gmail.com

CREDIT CARD PREAUTHORIZATION FORM

I authorize Ebony McClain, Ph.D.LPC to keep my signature on file and to charge fees, or partial fees, to my Credit Card account for services provided to

_____

(Print Patient or Client Name)

for the balance of charges not paid by insurance and not to exceed the amount of the full fee as detailed in the "Agreement for Psychotherapeutic Services" and Dr. McClain "Disclosure Statement" for each appointment including any fees for missed appointments or cancellations without 24 hour notice.

I agree that:

- if insurance benefits are assigned to Dr. McClain, I am still responsible for the total charges incurred regardless of any insurance denial or insurance partial payments unless other arrangements regarding fees have been made. The responsibility will be limited by any participating provider arrangements Dr. McClain may have with an insurance company or network.
- this authorization is valid until canceled in writing.
- charges for ongoing services will be posted to my credit card account within a week of each service date. Charges for completion of payment after a partial payment by my insurance company will be posted within a month of Dr. McClain receiving an Explanation Of Benefits from my insurance company. All charges will appear on my statement as "Ebony Counseling Consulting and Supervision". The amount charged on my account will depend on use of services, insurance arrangements, and agreement now in effect with Dr. McClain.
- if I have any problems or questions regarding charges to my account, I will contact Dr. McClain for assistance. ***I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Dr. McClain***

Cardholder Name (please print):_____

Billing Address (where your card statements are mailed):_____

City:_____ State:_____ Zip:_____

Card Type (circle one): Visa MasterCard Security Code:_____

Account # :_____ Exp. Date:_____

Cardholder Signature:_____ Date:_____

Ebony Counseling Consulting and Supervision

Ebony McClain, Ph.D., LPC, LCP-S
43 00B Street Ste 410
Anchorage, AK, 99503
Phone: 907-602-0305

Pre-Evaluation Questionnaire

To better help me serve you, please provide me with the following information prior to your intake assessment. All information is confidential and will be part of your clinical record. If you need more space feel free to attach addition paper. Please feel free to ask questions about any of the information requested. Thank you. (Attention: Parents completing form, provide child's information)

USE BLACK PEN ONLY

Date: _____ Name of Client: _____

DOB: _____ Gender: M / F Name and Relation to Client: _____

Marital Status of Client: Single Married Separated Divorced Other: _____

Please describe the main reason for your visit/current concerns: including behaviors, thoughts, and feelings In what situations, at what time or day(s), in what place(s) does this occur?

How often do you feel this way or have this problem?

Rate the intensity of the problem on a scale of 1-10: 1 2 3 4 5 6 7 8 9 10 less intense more intense

Family Medical/Developmental History

Do you have any drug allergies? Yes_ No_ If yes please list all drugs and the reactions they cause:

Are you currently taking any medications? Yes_ No_ If yes, please list all medications, dosages, times taken per day, and how long you have been taking them. (also include supplements (ie vitamins, herbs, etc.)

Do you have any currently active medical illnesses? Yes_ No_ If yes, please list them:

Do you have a history of any other medical illnesses? Yes_ No_ If yes, please list them:

Have you had any surgeries? Yes_ No_ If yes, please list the procedures, approximate dates, and any problems or complications:

Have you ever been knocked out or diagnosed with a concussion? Yes_ No_ If yes, please explain:

Have you ever had a seizure or undergone an EEG? Yes_ No_ If yes, please explain:

Have you ever had any neuro-imaging: (e.g. brain CT scan or MRI?) Yes_ No_ If yes, please explain:

What was your birth-weight?

Are you aware of any pre-natal exposures: (did your Mother drink or use any other substances while she was pregnant with you?) Yes_ No_ Not sure If yes, please explain:

Are you aware of any problems with your own birth? (when your mother was pregnant with you, during or shortly after delivery?) Yes_ No_ Not sure If yes, please explain:

Were you ever formally diagnosed with any developmental delays – learning to talk (and requiring a speech therapist), or to walk, or motor coordination? Yes_ No_ If yes, please explain:

Tell me about your biological family history: (this will help me understand what health issues may be of concern to you)

Do you have any biologically related relatives with a history of the following?

Depression? Yes_ No_ If yes, who:

Bipolar or manic-depressive illness? Yes_ No_ If yes, who:

Schizophrenia? Yes_ No_If yes, who:

Anxiety disorders or OCD? Yes_ No_ If yes, who

Post-traumatic stress disorder? Yes_ No_ If yes, who:

Eating disorders such as Anorexia Nervosa, Bulimia, or Binge Eating disorder? Yes_ No_ If yes, who:

Addiction? Yes_ No_ If yes, whom, what: Alcohol Marijuana Cocaine Amphetamines IV drugs Prescription drugs Other drugs/substances:

General medical illnesses (e.g. diabetes, cancer, hypertension}? Yes_ No_ If yes, whom, what:

Have you ever seen a psychiatrist? Yes_ No_ If yes, who, where, and when:

Have you ever seen a counselor or therapist? Yes_ No_ If yes, who, where, and when

Have you ever been diagnosed with a mental health condition? Yes_ No_ If yes, please explain what diagnosis, when, and by whom:

Have you ever been on psychiatric medications? Yes_ No_ If yes, please list names, doses, and approximate dates:

Have you ever been hospitalized for psychiatric reasons before? Yes_ No_ If yes, please list location and dates:

Have you ever attempted or seriously considered suicide? Yes_ No_ If yes, when:

Are you currently considering suicide? Yes_ No_ Do you have a plan? Yes_ No_

Current and/or Historical Substance Use

Do you currently use, or do you have a history of using in the past? Yes_ No_

Please check those that apply:

Tobacco/Chew/Nicotine gum or patch

Caffeine/ How Much

Alcohol Marijuana

Cocaine IV drugs Inhalants

Prescription drugs Heroin Amphetamines (include methamphetamine)

Hallucinogens

Illicit prescription drugs (e.g. oxycontin)

Family and Social History

Where were you born and raised?

Do you have any siblings?

How many, gender, ages?

Tell me about your educational history. Currently in school, grades, difficulties, diploma, GED, degree(s) attained?

Tell me about your work history (types of jobs have you held, where, what is your current employment status, military)

Do you have any current legal involvement and/or history of legal involvement? Yes_ No_ If yes, please describe

Have you ever been convicted of a crime (assault, DWI, theft)? Yes_ No_ If yes, please describe (don't include parking or minor traffic tickets)

Have you experienced any significant traumas in your life? Yes_ No_ If yes, please describe

Have you felt unsafe or at risk of violence in any of your relationships? Yes_ No_ If yes, please describe

Is there any other relevant information which you would like to be sure we discuss during our intake time?

HIPAA Privacy Information

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the Client, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

I have prepared this "Summary Notice of HIPAA Privacy Practices" to explain how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations:

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers.

- **PAYMENT** means such activities as obtaining payment or reimbursement for services, billing or collection activities and utilization review.

- **HEALTH CARE OPERATIONS** include managing your Electronic Medical Record to facilitate consultations with participating physicians, as well as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

I may also create and distribute de-identified health information by removing all references to individually identifiable information.
I may contact you to provide information about my services or other health-related services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

I have read and received a copy of the HIPPA policy

Client Signature: _____

Date: _____

Ebony McClain, PhD. LPC, LPC-S
Ebony Counseling Consulting and Supervision

4300 B Street Ste 410
Anchorage, AK, 99503
Phone: 907-602-0305
Email: ebonycounseling@gmail.com

Disclosure Information

Background of Ebony McClain:

Education and training: Ph.D. in Psychology. EMDR trained and hypnotherapy trained therapist

Certification: Licensed Professional Counselor (LPC) and LPC Supervisor in the State of Alaska

Professional Associations: American Psychological Association and Alaska Psychological Association

Approach to therapy: Person Centered. I use an eclectic approach to include experiential therapy and cognitive behavioral therapy.

Fees:

Intake Session: $300.00 per hour

Individual Therapy: $200.00 per hour

Family Therapy: $215.00 per hour

Group Therapy: $175.00 per hour

***Fees are subject to change. You will receive notice of future changes**

Cancellation Policy: You must cancel with 24 hour notice (see Informed Consent). Failure to do so will result in the credit card on file being billed for the cost of the appointment.

Business and Ethics Information:

Ebony Counseling Consulting and Supervision (ECCS) is a licensed business with the state of Alaska

Ebony McClain is the sole proprietor of ECCS and holds an LPC license in the state of Alaska.

Ebony McClain adheres to the standards of the American Counseling Association. A copy of the Code of Ethics for counselors may be found by visiting the American Counseling Association's website.

For more information please visit www.ebonycounseling.com and read through your informed consent.

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Ebony McClain, Ph.D, LPC, LPC-S

Mental Health Counseling

INFORMED CONSENT

Welcome, and thank you for choosing to work with me.

Before we begin, it is important that you read this document thoroughly. It contains important legal information, information about the counseling process, your rights, and my policies and procedures. Please read it carefully.

PSYCHOTHERPIST-CLIENT SERVICES AGREEMENT

This form has been developed to provide you with information about psychotherapy procedures and practices. It contains information about the Health Insurance Portability and Accountability Act (HIPAA), privacy rules and some professional ethical codes relevant to therapy. A separate notice has also been provided. You may choose to revoke this agreement at any time, which will mean you no longer consent to treatment; however some parts may still be enforced. Please be aware that you are not formally accepted as a client until expressly agreed upon by both parties (client and counselor) **AFTER** the Initial Intake Session.

PSYCHOTHERAPIST-CLIENT RELATIONSHIP

It is not appropriate for a Psychotherapist to engage in any relationship other than a Therapist-Client relationship with a client or former client and it is inappropriate to give or receive gifts. Any abusive behavior is inappropriate and will be grounds for termination of the therapeutic relationship.

CONFIDENTIALITY

Confidentiality is critical to your sense of safety and your ability to build a trusting relationship with me. You should know that I consult with other therapists on cases – I do not use names and I disguise identity of my clients, unless I have your written permission in advance. Consulting with others therapists allows me to give you a broader base of knowledge to drawn from in determining how best to serve you. There are a few situations in which confidentiality may be broken. They are as follows:

1) If I determine that you are at clear and imminent risk to harm yourself or others.
2) As mandated by law, including, for example, if there is a vulnerable child or adult at risk. I am mandated to report this to the appropriate authorities.

3) If a court subpoenas your records I am required to release them by law. However, you will be given notice of the subpoena and will have an opportunity to have the court "quash" or terminate the subpoena. Be aware that you would be responsible for taking this action as I cannot do this for you.
4) Where I am a defendant in a civil, criminal or disciplinary action and your records are part of any such action.
5) Where there is a waiver of confidentiality obtained in writing prior to such a release of information.

MINORS AND PARENTS

Clients under 18 and their parents should be aware that the law may allow parents to examine their child's treatment records. As specified by law, children 14 and over must consent to release information specifically pertaining to sexual activity and substance use. Because privacy in psychotherapy is crucial to successful progress, particularly with teenagers, we (the therapist, parent and teenager) will discuss confidentiality and what will work best in your particular situation.

COURT

Please be aware that I do not participate in court proceedings. However, if I am *required* to participate in court proceedings on your behalf, I will charge an $800 flat fee and $300 per hour for court appearances/testimony with an $1100 minimum. This fee will be assessed if I am *scheduled* for court on your behalf, and it is not contingent upon my actual participation or testimony. This fee is based on current client contract fees and **is not** an expert witness fee. You are responsible for these fees at the time of service.

ETHICS AND RECORDKEEPING

Licensed Professional Counselors abide by the American Counseling Association Code of Ethics (2014). Your records are maintained electronically in a secure electronic practice management system (Therapyappointment.com). Any paper documents in your record are kept in a locked filing cabinet behind a locked door. You have the right to copy of your record as requested.

In the event that I become incapacitated, a hired office assistant (who is bound by confidentiality) will take care of my professional matters.

ELECTRONIC COMMUNICATION

Unencrypted emails, texts, and other forms of electronic communication cannot be guaranteed to be secure forms of communication and may be intercepted by unauthorized third parties (e.g. computer

hackers). If you choose to communicate with me via electronic communication understand that you are taking a risk that your confidentiality may be compromised. It is also important for you to understand that I cannot be available at all times. Please do not expect responses to texts or emails on weekends or holidays. Email and text communication becomes part of your medical record.
I use an automatic system for appointment reminders if you've requested this.

APPOINTMENTS

Services are available by appointment. Unless otherwise specified, sessions are 45- 60 minutes long. Please try to be on time, as I may have someone scheduled directly after you. If you need to cancel a session, please do so 24 hours in advance by calling 907-602-0305 or emailing me at *ebonycounseling@gmail.com*. I have confidential voicemail so please leave a message. **Unless due to illness or an emergency, missed appointments or appointments canceled with less than 24 hours notice will incur a charge of the normal amount charged per hour. Your insurance will not pay for cancelation fees; you will be responsible for paying the full amount of the charge.**

EMERGENCY POLICY/ AFTER HOURS POLICY

My office hours and practice days may vary. I typically practice 4 days a week between the hours of 10:00 am and 5:00 pm. On non-practice days, I will check voicemails and return calls as necessary. I am unavailable to respond to emails and calls on weekends. During my work week it may take up to 48 hours for me to respond to emails. Please understand that during the day I am often unavailable due to being in client sessions. I do my best to check my voicemail during the day and I will do my best to respond within 1 to 2 business days.
Please be aware that I am not an on-call provider, so should you experience a crisis when am I unavailable, you should call 911, the Anchorage crisis line at 907-563-3200, or go to your nearest emergency room. It is important for you to acknowledge that you will take one of the actions above in case of emergency. As such, you are agreeing to hold Dr. McClain free of liability for abandonment or malpractice if she is not available to you during any circumstances, including the previously mentioned circumstances.

TREATMENT EXPECTATIONS

It is important to acknowledge and understand that there is an expectation that you will benefit from therapy. However, neither I, nor anyone else can guarantee that therapy will be successful. Therapy may deal with sensitive and/or difficult issues, which may elicit uncomfortable emotions, and may lead to individual decisions that are at least temporarily disruptive for oneself, family and other relationships. As a counselor, it is my job to assist you in achieving your goals.

PROFESSIONAL FEES

Fees are listed on the Disclosure Statement. Your insurance company will be billed for payment; you are responsible for the deductible and co-pay amount. Please verify your co-pay and deductible with your insurance company. I accept cash, credit cards, or personal checks. Please make your checks payable to Ebony McClain. Payment is expected at the start of each session. In the unlikely case that a check is returned, a $30.00 service fee is assessed. **In the event that your insurance company does not pay, you are responsible for fees incurred for services. I reserve the right to use a third party collector if a bill remains unpaid.**

_____ **I understand the HIPPA regulations and have been offered a copy.**

**Your signature indicates that you have read, understood and agreed to the terms in Ebony McClain, Ph.D., LPC Informed Consent document and are willingly entering into therapy with Ebony McClain, Ph.D., LPC. **

Signature (Client) Date

Signature (Parent/Guardian/Spouse) Date

Signature (Parent/Guardian/Spouse) Date