OneLight Christian Counseling PLLC
678-877-0016
allintothelight@gmail.com

INTAKE PACKET

NAME: _____ DOB: _____

SSN (Optional): _____ Today's Date: _____

IDENTIFYING INFORMATION

Home Address: _____City_____Zip_____

Email: _____ Evening Phone: _____ Daytime Phone: _____

Legal Guardian (if not self): _____ Daytime Phone: _____

Place of Work/School: _____

Spouse/Partner's Name: _____ Daytime Phone: _____

EMERGENCY CONTACT

First Contact: _____ Relationship to client: _____

Daytime Phone: _____ Evening Phone: _____

Physician's Name/Phone: _____

MENTAL HEALTH/BEHAVIORAL INFORMATION

Reason for Seeking Services: _____

_____

_____

Recent Treatment History (last 12 months): _____

_____

_____

Pertinent Medical Issues: _____

_____

Medications:_____

_____

Other Active Service Providers (last six months): _____

Court Involvement and/or Pending Charges: _____

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Primary Care Provider _____

Phone: _____

Preferred Method of Contact: (circle one) email home phone work phone cell phone/text

Tobacco use: none, daily, weekly, less, former user

Alcohol use: none, daily, weekly, less, former user
When consuming alcohol, what is most common over the past 12 months: 1 drink, several drinks, mild intoxication, intoxicated, blackouts

Have you ever experienced any legal ramifications due to substance or alcohol usage? Yes/ No
If so, what was the outcome? _____

Family history. Please circle all that apply

Adopted	Allergies
Arthritis/blood disease	Cancer
Depression	Diabetes
Hearing deficiency	High blood pressure
Learning disabilities	Tuberculosis
Osteoarthritis	PVD
Alcoholism	Asthma
Heart attack	Stroke
Developmental delay	Eczema
High Cholesterol	Irritable bowel disease
Obesity	Mental illness
Osteoporosis	Renal disease

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Briefly share what you expect from or hope to be the outcome of your time in counseling.

Are you seeking treatment of your own free will? Yes/No

Please briefly share any significant experiences you would like to address in counseling.

Average hours of sleep per night _____

Have you ever had a sleep study? Yes/No

If so, what were the results _____

Have you been prescribed a C-PAP machine or other such medical sleep device? Yes/No

If yes, how often do you wear it to sleep? Always, Most of the time, Sometimes, Rarely, Never

Additional comments or concerns –

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CONSENT FOR TREATMENT

Consumer Name (printed) _____

I hereby give my consent for Kathryn Bowden to provide the outpatient counseling services to the above-named individual. I have been informed of the scope and purpose of the service; the potential benefits and risks; and possible alternative methods of treatment. I understand that I may withdraw my consent at any time either verbally or in writing without threat or termination of services. In addition, I give consent for Kathryn Bowden to seek emergency medical care if needed. I understand I may refuse any services offered at any time. This consent will be valid for one year from the date signed unless the consent is withdrawn prior to that date.

Consumer Signature_____

CONTACT PREFERENCES **_____ NA** **_____ Initial**

I understand that one of my rights as a person served is to choose how I am contacted. I *DO/DO NOT (please circle one)* give permission for Kathryn Bowden to contact me at work. Furthermore, I *DO/DO NOT (please circle one)* give permission for Kathryn Bowden to leave voice messages for me at *HOME/WORK/BOTH/NEITHER (please circle one).* In case of an emergency or if you find that you are in Crisis, please call 911 or go directly to your local emergency room for evaluation.

Preferred contact number _____

RECEIPT AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Consumer Name (printed) _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Kathryn at 678-877-0016 or discuss it with her at my next session.

_____
Client Signature

_____
Date

NORTH CAROLINA NOTICE FORM of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"

– Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician, psychiatrist or another psychologist.

- Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our

conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

(1) I have relied on that authorization; or

(2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: 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. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, I must do so

Adult and Domestic Abuse: If information you give me gives me reasonable cause to believe that a disabled adult is in need of protective services, I must report this to the Director of Social Services.

Health Oversight: The North Carolina Board of Licensed Professional Counselors has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.

Judicial or Administrative Proceedings: If you are involved in a court proceeding, and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: I may disclose your confidential information to protect you or others from a serious threat of harm by you.

Worker's Compensation: If you file a workers' 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.

IV. Patient's Rights and Counselor's Duties

Patient's Rights:

- Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations –You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically

Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I am required by law to take reasonable steps to protect unintentional disclosure through breeches of security, such as computer viruses and electronic transmission of data.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a hard copy during your next office visit

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me in writing. We will then set up a meeting to discuss these concerns with the intent to seek a mutual resolution.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on May 13, 2019.

I will limit the uses or disclosures that I will make as follows

- Your written consent is obtained, except where disclosure is required by law.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If changes are made, I will provide you with a hard copy during your next office visit

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Professional Disclosure & Informed Consent Form

Consent to Treat a Minor

Dear parents or guardians:

We consider it a privilege to meet your family's counseling needs. During the first session, the counselor will ask to speak with you to discuss goals, concerns and obtain a brief history of the client. Although each counselor has their own counseling style, parents or guardians are often asked to speak with the counselor before or after each session to give an update on any issues. Feel free to bring with you any information you may think the counselor might find helpful.

Parents/Guardians, please note that if a counselor is notified that anyone is in danger of harming themselves or someone else, you will be notified immediately. Parents/guardians are required to stay on the premises during each session.

By signing below, you give permission to Kathryn Bowden MA, LCMHCA (supervised by Troy Kane MA, LCMHCS, NCC) to see your minor child for counseling, testing, or assessment.

Client's name (print) Date

Parent or Guardian's name (print) Date

Parent or Guardian's signature

Professional Disclosure Statement
Kathryn M. Bowden MA
678-877-0016
allintothelight@gmail.com

My Qualifications

I received both my undergraduate degree in psychology in 2017 as well as a Master of Arts: Professional Counseling in 2020 from Liberty University. I began counseling under supervision in May of 2019.

Restricted Licensure

I am licensed as a Clinical Mental Health Counselor Associate in North Carolina. Currently, I am working under the supervision of Troy Kane, MA, LCHCS, NCC located at 8512 Six Forks Rd., Suite 101 Raleigh, NC 27615.

Counseling Background

I provide counseling services with a Christian focus when requested, for individuals ages 12 and up as well as couples. As a counselor, I take a holistic approach utilizing Cognitive Behavioral Therapy as well as Narrative Therapy as I strive to tailor the treatment approach to each client individually.

Session Fees and Length of Service

Sessions run 50 minutes but the initial intake session may last up to 75 minutes. The initial intake session is $110 with the charge for each session thereafter at $100. A limited number of sessions are available by sliding scale starting at $65 per session. While we understand emergencies may arise, missed appointments, or cancellations less than 48 hours in advance may result in a $75 charge. OneLight Christian Counseling PLLC is not in network with any insurance carrier however, any documentation needed in order to file as an out of network provider can be supplied on request. Payment in the form of cash, check, debit or credit card is accepted.

Confidentiality

Our work together is confidential. What you choose to discuss with me is private and protected by federal and state laws. Except under unusual circumstances, as stated below, I will not share anything we talk about with others unless I have your written permission to do so. You may direct me to share

information with whomever you choose and you can change your mind and revoke that permission at any time. I will always act to protect your privacy.

Limits of Confidentiality

Confidentiality will conform to state guidelines and the ethical guidelines of the American Counseling Association. All counselors-in-training and their supervisors will not disclose information expect under the following conditions:

- The client or guardian gives written consent to release information to a designated individual or agency
- The client makes specific violent threats to harm him or herself or to harm an identifiable victim
- The counselor and/or their supervisors are named as defendants in a civil, criminal, or disciplinary action arising from the counseling session
- The counselor receives an authentic court order backed by judicial authority that requires the disclosure of information
- The counselor has reasonable cause to believe that a child, an elderly individual, or adult with a disability has suffered abuse or neglect
- The counselor will discuss the content of counseling sessions in individual supervision under the direction of a qualified supervisor who is held to the same standards of confidentiality and its limits

Complaints

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

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

Acceptance of Terms

We agree to these terms and will abide by these guidelines.

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allintothelight@gmail.com

INTAKE PACKET

Client: _____ Date: _____

Counselor: _____ Date: _____