WILBORN CLINICAL SERVICES

Building a healthy community, one client at a time.

Registration

DATE _____ REFERRED BY _____

CLIENT NAME_____ PREFERRED NAME _____

SOCIAL SECURITY# (Required)_____D.O.B_____ AGE _____
RACE_____GENDER_____

RELATIONSHIP STATUS: SINGLE MARRIED DIVORCED WIDOW

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE HOME _____CELL _____

EMAIL ADDRESS_____

CIRCLE PREFERRED NUMBER FOR CONTACTING YOU: HOME CELL WORK

MAY WE LEAVE A MESSAGE ON THIS PHONE? Y/N

EMPLOYER
NAME/ADDRESS_____

SCHOOL NAME/
ADDRESS_____

EMERGENCY PHONE _____ EMERGENCY PERSON _____

FAMILY MEMBER'S TELEPHONE # AND ADDRESS **NOT** LIVING WITH YOU:

_____

_____

GUARDIAN INFORMATION: **(CHILDREN AND YOUTH ONLY)**

Parent/Guardian _____ Relationship _____

Address_____ City _____ State _____ Zip _____

Legal Guardian**:** __ Biological Parents __Mother __ Father __ State/DCS __Other

Are you involved in a divorce or custody case? ___Y ___N

RESPONSIBLE PARTY

NAME _____ DATE OF BIRTH _____

RELATIONSHIP _____

ADDRESS_____STATE_____ZIP_____

PHONE _____ SOCIAL SECURITY_____

EMPLOYER _____

ADDRESS_____

INSURANCE INFORMATION

PRIMARY CARRIER: _____

RESPONSIBLE PARTY:_____ DOB: _____

MEMBER/GROUP ID#: _____

EFFECTIVE DATE: _____

SECONDARY CARRIER: _____

RESPONSIBLE PARTY:_____ DOB: _____

MEMBER OR GROUP ID#: _____

EFFECTIVE DATE :_____

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Client Rights And Responsibilities

RIGHTS:

You have the following rights:

- The right to participate in planning your treatment program.
- The right, to the extent permitted by the law, to refuse specific treatment, procedures, unless there is danger of harm.
- The right to file a grievance, should you feel you are treated unfairly.
- The right to confidentiality.
- The right to be free from discrimination including discrimination because of race, religion, sexual preference, age or disability.
- The right to privacy as appropriate to your treatment setting.

RESPONSIBILITIES:

Your willingness to actively participate in treatment plays a crucial part in achieving treatment success. Therefore, you have the following responsibilities:

- The responsibility to provide accurate and complete information as needed for your treatment planning.
- The responsibility to update any changes in information needed for your treatment planning.
- The responsibility to make it known whether or not you understand your treatment plan.
- The responsibility to actively participate in your treatment.
- The responsibility to indicate when you are unwilling and/or unable to comply with your treatment plan.
- The responsibility for your actions if you refuse to comply with treatment plan recommendations.
- The responsibility to follow all rules and regulations established to maintain a safe treatment environment.
- The responsibility to respect the rights and confidentiality of others.

Client's Signature: _____ Date: _____

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Consent for Evaluation and Treatment

Clear and direct communication is important for effective counseling services. This handout is to provide you with clear information regarding practice polices. It is important that you understand this information so please ask questions you have about the information provided.

CONFIDENTIALITY: Information regarding treatment is controlled by the client. There are exceptions to this rule:
1) By law, Wilborn Clinical Services is required to take whatever actions seem necessary to protect clients from harm.

2) Wilborn Clinical Services is required to contact the Department of Human Services if there is a reason to believe that someone is abusing or neglecting children, or a dependant adult.

3) If you have been referred to Wilborn Clinical Services by court, you can assume that the court wishes to receive a report of the evaluation. In such instances, Wilborn Clinical Services will consult with you regarding the information requested and discuss written authorization to release the information.

4) If you are involved in legal actions of any kind and inform the court of services that you receive services from Wilborn Clinical Services, you will be making your mental health an issue before the court. You may be waiving your right to keep your records confidential. You may wish to consult with your attorney regarding such matters before you disclose that you have received mental health treatment.

5) Most insurance companies, other payers, or manage care companies require the provider to release information regarding diagnosis, type and place of service, date of service, treatment plan, or other confidential information.

* Wilborn Clinical Services requires a formal, written, release form to be completed to release any information, verbal or written, unless required by law, or the release is needed to coordinate treatment with another healthcare professional, or for payment purposes, or for general health care operations. For more information, see Notice of Privacy Practices.

BENEFIT AND RISK OF THERAPY: Therapy is an interactive process between the client and therapist. It is meant to promote change and understanding. Sometimes this process is very fulfilling but also can be emotionally difficult. You will be expected to contribute to decisions regarding interventions, including out of

session tasks. You have the right to refuse or alter any intervention. You are encouraged to question the rationale of treatment if it is unclear to you. While I have every expectation of helping you determine and achieve personal therapeutic goals, no specific outcome cannot be guaranteed.

AFTER HOURS POLICY: In the event of an emergency, clients should call 911, or go to the closest emergency room.

CREDENTIALS: See Declaration of Practices and Procedures.

BY SIGNING MY NAME BELOW I SHOW THAT I HAVE READ THE ABOVE INFORMATION AND IF NEEDED IT HAS BEEN EXPLAINED TO MY SATISFACTION. I HAVE HAD ALL MY QUESTIONS ABOUT FEES, CONFIDENTIALITY, INSURANCE OR OTHER MATTERS ANSWERED, AND HAVE RECEIVED A COPY OF THIS CONTRACT IF SO REQUESTED.

I, _____, HEREBY CONSENT TO EVALUATION AND TREATMENT.

Signature _____ _____
Date

_____ _____
Witness Signature Date

WILBORN CLINICAL SERVICES

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Financial Agreement (Required for Services)

We are committed to providing you with the best possible care. In order to help you achieve your therapeutic goals, we need your assistance and understanding of our payment policy.

Payment is due at beginning of each session. We must emphasize that as providers of service, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our clients, all charges are your responsibility from the date services are rendered. It is your responsibility to follow up with your insurance company and pay all remaining balances.

If you are unable to keep an appointment, please notify us 24 hours in advance to cancel your appointment. This will enable us to accommodate other clients. **If you cancel 24 hours or less before your appointment time, or do not show for your scheduled time, you will be charged for the full session**. Insurance companies will not pay for cancellation charges, therefore this charge is your responsibility.

There may be charges for other services provided by Wilborn Clinical Services. Services that are not normally required for billing or treatment purposes such as phone consults over 15 minutes and clinical record requests will be charged an additional rate.

In the event that the account becomes delinquent, the responsible party agrees to pay for attorney or collection fees that might occur. The account will become delinquent after it has matured to 60 days from the date of service. Wilborn Clinical Services will determine the collection agency.

Credit Card Authorization

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case (non-emergencies) where you miss or fail to cancel an appointment within **24 business hours** of the scheduled time, you will be charged the full session fee.

I, _____, hereby authorize Wilborn Clinical Services to bill my credit card at the usual fee for professional services plus 4% processing fees including all of the following:

- Appointments that I elect to pay for by credit card
- Missed appointments

- Telephone consultations lasting longer than fifteen minutes
- Appointments that I have cancelled (non-emergencies) with less than 24 hours' notice
- Unpaid balances due to unpaid insurance claims

Credit Card/Debit Card Type (check one): □ Visa □MasterCard □American Express □Discover

Card #_____ Expiration Date: _____

Verification/Security Code (3 digit code on back of card by signature line): _____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

By signing below you have agreed to all the terms in this financial agreement.

Signature: _____ Date: _____

Print Name: _____

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Primary Care Physician Communication Form

Communication between behavioral health providers and primary care physicians / psychiatrists is important to help ensure all clients receive comprehensive and quality health care. This information is not released without the client's consent. This information may include diagnosis and treatment planning if necessary. Below please find the consent or refusal to release said information. The client may revoke this consent at any point, in writing, except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified.

____I authorize communication with my primary care physician

Name/Practice Name: _____

Address: _____

Phone Number: (____) _____

Fax Number: (_____) _____

____I decline communication with my primary care physician

(Completed by provider)

This client was seen at my office for mental health treatment as a result of:

___Direct client call to my office
___Post Psychiatric client admission
___Referral from Psychiatrist
___Referral from insurance company
___Referral from PCP
___Referral from school/work
___Other_____

This authorization expires one year (1) from today's date _____ or on this date_____

_____ _____

Client Signature/Parent Date

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Client Questionnaire

Name: _____ **DOB:** _____

Briefly describe your goals for counseling:

_____

_____

_____

_____

_____

Anxiety	Depression	Mood instability
Substance Abuse	Addiction	Self-Control
Anger	Stress	Sadness
Sleep	Relaxation	Energy
Work	Education	Ambition
Eating	Weight	Appetite
Concentration	Making Decisions	Thoughts
Legal Matters	Domestic Violence	Discrimination
Loneliness	Relationships	Marriage/Divorce
Children	Parenting	Fertility
Health Problems	Pain management	Trauma

Other: _____

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Notice of Privacy Policy

1. **Uses and Disclosures:** Wilborn Clinical Services (WiCS) is permitted by law to disclose the minimum necessary personal health information of each client to carry out treatment, payment and health care operations of WiCS. For treatment purposes, such disclosures may be made to physicians and other health care providers as necessary to facilitate the appropriate treatment and care of clients. Personal health information may be disclosed to the government or other third party payors for the purpose of obtaining payment for services provided. Wilborn Clinical Services may also use personal health information to carry out WiCS' day- to-day operations such as scheduling, quality review, and appointment reminders. A list of other examples of disclosures can be obtained from the Privacy Officer, Tammy Lewis Wilborn, PhD, LPC-S, upon request.

2. **Required Authorizations**: Wilborn Clinical Services will not disclose any client's personal health information for any purpose aside from payment, treatment and health care operations, without client's written authorized consent to such disclosure. Wilborn Clinical Services will use and disclose personal health information when required by federal, state, or local law, and/or for Worker's Compensation or similar programs that provide benefits for work- related injuries or illnesses.

3. **Privacy Compliance**: In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 (the "Privacy Regulations"), Wilborn Clinical Services has adopted privacy policies regarding usage of clients' personal health information. Wilborn Clinical Services is committed to compliance with the Privacy Regulations and all other laws and regulations regarding clients' right to privacy. In accordance with the Privacy Regulations, you are permitted to request an amendment of your protected health information and to receive an accounting of disclosures made for purposes other than treatment, payment or operations

4. **Additional Information**: For additional information regarding Wilborn Clinical Associates' privacy policy or for a copy of this notice, please contact our Privacy Officer. Wilborn Clinical Services reserves the right to change this Notice and to make the revised and changed notice effective for clinical information that Wilborn Clinical Services already has about you, as well as any information Wilborn Clinical Services receives in the future. We will post a copy of the current notice in Wilborn Clinical Services offices. The notice will contain the effective date.

The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

Client Signature: _____ Date: _____

DECLARATION OF PRACTICES AND PROCEDURES

Tammy Lewis Wilborn, PhD, LPC-S, LPC/MHSP, NCC
PO Box 872873
New Orleans, Louisiana 70187
(504) 509-3995

Qualifications: I am licensed as a LPC-S #6422 with the Louisiana Board of Examiners, 8631 Summa Avenue, Baton Rouge, LA 70809; phone (225) 765-2515. I am a Board Approved Clinical Supervisor of Provisional Licensed Professional Counselors (PLPCs). I am also a licensed professional counselor (LPC) board certified and licensed by the Tennessee State Board of Licensed Professional Counselors, Marital and Family Therapists, and Licensed Pastoral Therapists (#2351). I have a Ph.D. in Counselor Education and Supervision from University of North Carolina at Charlotte (2015; CACREP-accredited), MS in Counseling (2003; CACREP-accredited), and a B.A. in Psychology (1999) from Loyola University of New Orleans. I am also a National Certified Counselor (NCC; #342407). I also hold active memberships with the American Counseling Association, Louisiana Counseling Association, Association for Counselor Education and Supervision, and Louisiana Association for Counselor Education and Supervision.

Experience: I have 15+ years of clinical experience including internships providing individual, group, and family counseling to children, adolescents, and adults. I have experience treating a number of issues: child and adolescent disorders, clinical and mood disorders, trauma, addictions, domestic violence, couples and marital issues, employment issues, academic, and eating disorders.

Nature of Counseling: Counseling provides the opportunity for healing, growth and self-discovery in the context of a safe, supportive, and therapeutic relationship. I use a multi- modal approach that includes cognitive behavior therapy (CBT) along with reality, and existential therapy. Treatment planning may involve the use of clinical diagnoses that can become a permanent part of your client records.

INFORMED CONSENT

Counseling Relationship: Sessions are weekly 50-minute sessions for individual therapy and 90 minutes for couples, family and group therapy. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Please do not invite me to social events, bring gifts, ask to barter or exchange services, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling relationship. I do not discriminate on the basis of race, gender, religion, national origin, sexual orientation, or physical disability.

Effects and Risks of Counseling: Counseling involves personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your career and/ or academic interests, as well as a better understanding of yourself and others. Although it is my complete desire

and intent that you benefit from counseling, I cannot guarantee any specific results. However, it is important to share with me when you are not experiencing positive therapeutic effects so we can work through this together to help you achieve maximum therapeutic benefit.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

Code of Conduct: I render counseling services in a professional manner consistent with accepted ethical standards governed by the American Counseling Association (ACA) Code of Ethics and the Code of Conduct that has been adopted by my licensing board, the Louisiana LPC Board of Examiners. A copy of the ACA Code of Ethics and the LA LPC Board of Examiners Code of Conduct is available to you upon request. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the:

STATE OF LOUISIANA
LICENSED PROFESSIONAL COUNSELORS BOARD OF EXAMINERS
COMPLAINT COMMITTEE
8631 SUMMA AVENUE
BATON ROUGE, LOUISIANA 70809
TELEPHONE (225) 765-2515

Appointments, Cancellation, and Crises: I respectfully ask that you give me 24 hours notice if you need to cancel or change an appointment for anything other than an emergency. Failure to give such notice will result in your being charged the full fee for the missed appointment. If an emergency occurs, please contact me as soon as possible to avoid being charged.

1. If you are late for a session, I may either cancel your appointment or meet with you for a briefer session. Either way, I may charge you for the full session. Charges for missed or late sessions are your responsibility.
2. I may also need to cancel an appointment at the last minute due to an emergency or illness. Every attempt will be made to contact you as soon as possible, but there may be times that I am unable to reach you prior to your arriving for your appointment. Please be sure that I have all contact information in the event I need to reach you on short notice.
3. If you experience a mental health emergency, please call 911 or go to your local emergency room

Fees and financial considerations:

1. My standard fee for individual counseling range from $100 to $120 per 50-minute session. Couples and family counseling are $200 per 90-minute session. The fee for an intake assessment is $80 for

individuals and $150 for couples/marriage/family. Sliding fee scale may be available on a limited basis. If a sliding fee is offered, the amount will be reviewed every three (3) months for eligibility.

2. Payment in full for services provided is expected **at the beginning of each session**. This includes the cost for self-pay (uninsured) services, co-payments, deductibles and late fees. I accept cash and debit/credit cards.
3. As a courtesy, I can contact your insurance company prior to your first session to obtain any necessary authorization for services as well as to seek re-authorization for approval of more sessions, if necessary. You will be responsible for any fees that result from your failure to inform us of any insurance changes as well as verifying:

    a. That the services have been authorized and the number of sessions approved.
    b. The amount of any deductible and/or co-payment.
    c. The potential limits on number of sessions that may be authorized.
    d. Any restrictions on the kind of services or problems that they cover.

Confidentiality & Records:

Confidentiality: Please refer to "Notice of Privacy Practices" sheet for additional detailed information regarding confidentiality. Discussions between you and I are confidential. However, exceptions to confidentiality do exist. These exceptions include, but are not limited to, the following situations: 1) you or your legal representative direct or consent in writing that I release your records; 2) you are an imminent risk to self and/or others 3) I learn that you are involved in the abuse, neglect, or exploitation of a child, elderly (60 or older), or disabled person 4) I learn that you are infected with a potentially life-threatening illness that could be transmitted to a specific uninformed person, and/or 5) I am otherwise required by court order to disclose information.

Records: All of our communication becomes part of the clinical record, which is maintained in the form of paper files. Client records are destroyed seven years after termination.

Consent to Treatment: By your signature below, you are indicating 1) that you voluntarily agree to receive mental health assessment and mental health care, treatment, or services, and that you authorize me to provide such assessment and care, treatment, or services as I consider necessary and advisable 2) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such care, treatment, or services that you receive through me 3) that you have read and understood this statement and have had ample opportunity to ask questions about, and seek clarification of anything unclear to you and 4) that I provided you with a copy of this statement. By my signature, I verify the accuracy of this document and acknowledge my commitment to conform to its specifications.

_____ _____

Client /Date **Tammy L. Wilborn, PhD, LPC-S, NCC/ Date**

Parent/Guardian Consent for Treatment of a Minor:

I, _____, give my permission for **Tammy Wilborn, PhD, LPC-S, NCC** to conduct therapy with my _____, _____.

(Name of parent or legal guardian)

(Relationship) (Name of minor)

Signature of Parent or Legal Guardian/ Date