Harmony Health Therapeutic Services, PLLC
5820 East W. T. Harris Blvd Suite 205 Charlotte, NC 28215
T 704-469-1243
F 704-469-1713

Adult Intake

Medical Record #: _____ Date: _____

Referred by:_____

Name: _____
Last First Middle Maiden

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone:(H): Area Code ( )_____(W): Area Code ( ) _____

Is it safe to call you at home? _____ If not, where can we contact you? _____

Email: _____

Date of Birth: _____ Race: _____Age: _____Gender: ____

Marital Status: Divorced? ___ Separated?___ Currently living together?___ Married?___

Social Security Number: _____ (For internal record keeping purposes only)

Spouse/Partner Name: _____
Last First Middle

Street Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Phone:(H): Area Code ( )_____(W): Area Code ( )_____

Billing Information:

Current Household Income: *(Please check the appropriate box)*

_____$0-$10,000 _____$30,001-$40,000 _____$75,001+

_____$10,001-$20,000 _____$40,001-$50,000

_____$20,001-$30,000 _____$50,001-$75,000

Current Housing Situation:

_____Own House _____Rent House/Apartment

_____Share housing with others _____Shelter

_____Transitional Housing _____Other

Current Employer: _____

Phone: _____

Current Occupational Status: (i.e., F/T, P/T, self-employed, unemployed, student, returning to work): _____

Primary Insurance: _____ ID #:_____

Group #: _____

Subscriber Name: _____ Insurance Phone: _____

Subscriber DOB: _____

Emergency Contact Name: _____ Subscriber SSN: _____

Contact Relationship: _____

Emergency Contact Phone: _____

Present Situation:

Please state why you decided to come for services: _____

_____

_____

_____

_____

_____

How long has this been a problem for you:

_____

Please explain your goals for you:

_____

_____

_____

Have you been to counseling before: ____ Y ___ N

Name of agency: _____ Phone: _____

Address: _____ How long? _____

City, State: _____

Primary Care Physician: _____ Phone: _____

Address: _____

City, State: _____

Members of Household (if different from above)

Name (Last, First, Middle) DOB Gender/Race Person's Relationship to Child

_____

_____

_____

Name of agencies involved with: _____

_____

DSS Case worker (if applicable): _____

Phone Number: ( )_____

CONSENT FOR SERVICES

I, _____ Consent to Services provided by

HARMONY HEALTH, PLLC.

- I understand that counseling sessions are not to be recorded in any form by client(e.g. video, audio).
- I authorize release of information necessary to complete insurance forms, if applicable. I am responsible for any indebtedness incurred as a result of services rendered to me or those under my guardianship by this therapy or testing.
- I understand that if, during the course of treatment, the counselor determines that a threat of physical harm (including child or elder abuse) to the client or to another person is imminent, by law, the appropriate authorities must be notified, in accordance with the following North Carolina Statutes:
- I further agree to indemnify and hold harmless Harmony Health, PLLC, its agents, volunteers or employees from any claim for damages of any nature arising out of or allegedly due to any counseling, instruction or advice rendered by personnel of Harmony Health, PLLC, or out of any activity related thereto.
- I accept full responsibility for any decisions I make regarding my life.
- I have read the above information carefully, understand its contents, and agree, under these conditions, to receive services for myself and/or anyone herein designated.

_____

Name [print]

_____ _____

Signature Date

Name:_____ For office use: MR # _____ Ins #_____

Harmony Health, PLLC

At Harmony Health, we value your privacy and urgent needs. Please take time to review the following policies and crisis information. Please initial next to each policy/info indicating that you have read and understood the information and sign your complete name and date at the bottom of the page. If there is something that you do not understand, please review with your contact during your intake to explain further before signing this form.

1. ____ Client's Rights NC General Statue 122C-52-56
2. ____ Your Rights UNDER HIPAA Privacy Rights
3. ____ HIPAA Privacy Rule and Sharing Information Related to Mental Health
4. ____ Disability Rights North Carolina
5. ____ Copy of Crisis Contact Number
6. ____ Copy of our Client Handbook with Rights, Responsibilities, Policy and Procedures [emailed in your Client Portal]. If not, Please Request a Physical Copy of the Handbook.

I have read, reviewed and understood all of the above initialed items. I have been informed of my privacy rights under state and federal laws. I have received a copy of the Client Handbook which includes my client's rights. I am confirming acknowledgement of all stated above.

_____ _____

Client Printed Name Date

_____ _____

Guardian or Responsible Person for clients under 18 Date

_____

Signature

CONSENT TO RELEASE INFORMATION

Name:_____ For office use: MR # _____ Ins #_____

CLIENT'S NAME _____ MR # _____ DATE_____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

I authorize **Harmony Health, PLLC** to release/obtain information in my/my child's record to:

AGENCY _____ PHONE _____

NAME _____ TITLE _____

Information is being released by: writing __X__ telephone __X__ fax __X__

Information to be released:

_____

Specific Purpose: ___coordination of services_____

This consent shall be valid until (not to exceed one year) _____

I hereby authorize release of the above information. I understand I may withdraw my consent to release this information at any time, except to the extent that action based on this consent has been taken. The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are or may be statutes and regulations protecting the confidentiality of the information. I hereby acknowledge that this consent is given freely, knowingly and voluntarily.

Client's Signature _____ Date _____

CONSENT TO RELEASE INFORMATION

CLIENT'S NAME _____ MR # _____ DATE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

I authorize:

AGENCY _____ PHONE _____

NAME _____ TITLE _____

to release/obtain information in my/my child's record to: **Harmony Health, PLLC.**

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Client's Signature _____ Date _____

Therapeutic Services Fees Schedule:

Private Pay/Self-Pay
Clinical Assessment: $150
55 Minute Individual Therapy Session: $125
30 Minutes Therapy Session: $50
90 Minute Group Session: $50
50 Minute Family Session: $125
50 Minute Couple's Session: $125
50 Minute Parenting Session: $50

NO SHOW Policy: If you fail to show for your appointment, there will be a $25 charge. Cancellation must be made within *48 hours* of appointment time or will count as a no show.
**This does not apply to Medicaid Members*

You can cancel your appointment by:
Email: Intake.HarmonyHealthPllc@gmail.com, Call: 704-469-1423 by phone and leave a voice message or USE your Client Portal to cancel 48 hrs before appointment to avoid cancelation fees.

If you are More than 15 minutes Late for your appointment, You may have to reschedule and can be charged a No-show fee.

Private/State Insurance:
Co-Pay- determined at time of service based on your insurance.
Payment due at time of service.

3rd Party Billing:
You are responsible for any portion of services not covered by your support or financial responsible person/entity.
Please request invoice for service for reimbursement at time of service.

I agree to these terms of services and fees associated with services. I understand that I will be held financially responsible for any portion of fees not paid by insurance or other 3rd party billing agents. Payment is due at time of service.

_____
Client/Responsible Person print Name:

_____ _____
Client/Responsible Person Signature: Date: