Diane Myers LCMHC Outpatient Therapist

Direct- (919)-335-3365

LifeCare Counseling & Coaching

190 Rosewood Centre Ct, Suite 100

Holly Springs, NC 27540

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LCMHC Professional Disclosure Statement

Counseling Relationship:

This intake form is for the purpose of getting to know you better in order to provide the best possible mental health services. The counseling relationship is collaborative in nature. Counselor and counselee work together on identified problems, developing a plan to meet specified goals. In each session we will review progress toward identified goals, assess next steps and focus on immediate objectives. Counseling only provides results if the client is willing to attend in a timely and regular manner, holds a willingness to change certain behaviors, while being vulnerable on some level to put the work needed into *the process* to reach desired goals. The counseling relationship is built upon a foundation of trust, honesty and openness between the counselor and counselee.

About Your Counselor: Diane Myers, MA, LCMHC

I hold a Masters of Arts in Counseling, attained from Liberty University, in Lynchburg VA

i have experience through Easter Seals UCP as well as with Hope Services, with “At-risk” children ages 7-13, where I worked as an associate professional (AP) providing intensive in home treatments. I have over 11 years professional experience with children & adolescents combined, 4 years volunteer work with the elderly and 7-years of experience in private practice. I have been trained to work with those struggling with anxiety, anger management, depression, BPD, OCD, parenting issues and relationship issues to name a few, with extra training in trauma therapies.

Trained in Cognitive Behavioral Therapy (CBT), Cognitive Therapy, Psychotherapy, Dialectical Behavior Therapy(DBT), Eye Movement Desensitization & Reprocessing (EMDR), Written Exposure Therapy (WET) and other Mindfulness approaches.

I am currently serving young adults 18yo and older, through individual therapy as well as couples or marriage therapy.

I have been happily married over two decades and have children of my own, I enjoy spending quality time with my family outdoors. I am passionate about marriages and believe they are one of the most important relationships we are a part of. When we are our healthiest selves, mind, body and spirit, it transfers to all of our other relationships. I look forward to working alongside you in a therapeutic, collaborative relationship strengthening your relationships and helping you reach your goals.

Treatment, Services and Fees

I currently work for LifeCare Counseling & Coaching in Holly Springs, NC located at 190 Rosewood Centre Ct, Suite 100, Holly Springs NC. I am an out of network provider for BCBS and Aetna insurance companies. The current hourly rate is 170.00 per hour unless otherwise specified, at which time the lesser amount will be documented in writing and signed by both the counselor and counselee, for a specified number of sessions. Insurance companies consider their rates of reimbursement a "trade secret", meaning they will not disclose to you, how much you will receive from them per session until your first check of reimbursement is actually paid out to you. I am happy to provide you with the necessary paperwork to submit a claim to your provider on your own. You will then be reimbursed directly from your provider, as you will have already paid me for my services.

Methods of payment accepted include cash, credit/debit card, we utilize a HIPPA Guarded payment service called Therapy Appointment that you will set up one time, prior to your first session. Your information can be changed at any time in the future via your portal.

Cash, Credit/Debit Card payments are accepted methods of payment.

Responsible Party

If person responsible for payment and charges is same as client, write SELF and go to next section.

Full Name: _____

Relationship to Client: _____

DOB: _____

Address: _____

Preferred Phone: _____ Cell □ Home □

E-mail Address: _____

Session Fee: _____

Number of Sessions at Discounted Rate: _____

Credit Card You Prefer To Be Kept On File for Reoccurring Payment Option and/or for payment collection for missed appointments without a prior 24 hour notice of cancellation via email or phone call.

I give authorization to charge my credit card $150.00 for a no-show fee if I fail to cancel my or my dependent's appointment 24 hours prior to the scheduled counseling session. I understand that it is my responsibility to keep an updated copy of my credit/debit card information on file. If my credit/debit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or card.

_____ Date _____

Client/Legal Guardian Signature

Credit Card □ Visa □ MasterCard □ Discover

Card Number _____

Expiration Date ____/____

CCV: _____

Billing address/zip code _____

Full Name as it appears on card _____

Your session will start on time and last for 50-60 minutes. Your counselor will utilize Cognitive Behavioral Therapy, Cognitive Therapy, Dialectical Behavioral, EMDR, WET or Mindfulness Therapy and will be explained to you in an understandable manner at the first session. Diagnoses given do become a permanent part of your client record. You can expect to learn specific skills during sessions to encourage change to reach specified goals, enhance relational interactions, enhance self-esteem and confidence, you will be given the chance to utilize new skills taught within the session. The counseling process can sometimes be uncomfortable and challenging, however, there will be no harm from engaging in the counseling relationship. If there should ever be a negative effect due to utilizing new skills, it is expected that you would bring this up in session where modifications can be made. Safety is always the primary concern and focus in the counseling relationship.

I will enter our relationship with hope and expectations for positive change. It is important, however, that you understand there are possible risks as well as benefits of counseling. Risks might include uncomfortable levels of feelings like sadness, guilt, anxiety, anger or frustration, or you may experience difficulties with others. Sometimes, relationships can take unaccustomed directions that feel quite awkward at first. That initial awkwardness can occur no matter how you evaluate the balance between the long-term costs and benefits compared to the old ways of relating. Decisions you make regarding these areas of your life will remain your responsibility.

After Hours Calls/Emergencies:

Cancellations and changes to appointments can be made during or after business hours at (919) 851-1527 or to dianemyerslpc@gmail.com we will get back to you as soon as possible, in the event of an emergency or crisis, call 9-1-1, 988 or utilize the emergency department at your local hospital. or call Triangle Springs Psychiatric Hospital is 919-371-5568, or Holly Hill Psychiatric Hospital is 877-664-5787.

Emergency Contact:

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you- Perhaps a relative, spouse, adult child or close friend. I am also required to contact this person, or the authorities, if I become concerned about you harming someone else. Please write down the name and contact information for your emergency contact person.

Full Name: _____

Relationship to you: _____

Phone: _____

Address: _____

E-mail: _____

M**issed Appointments:**

We ask that you change or cancel all appointments at least 24 hours in advance before your scheduled time. Frequent cancellations will be addressed as they occur if necessary. Please take the time to record your appointments into your personal calendar(s). Keeping up with your scheduled appointment is your responsibility, you may not receive a reminder email, call or text. Therapists at LifeCare Counseling and Coaching reserve the right to charge $150.00 for missed appointments without a prior 24 hour cancellation call, text or email.

Confidentiality:

Your counselor respects your right to privacy and will avoid unwarranted disclosures of confidential information. However, complete protection of privacy cannot be guaranteed even with safeguards in place. In rare cases, courts may order disclosure of records. Confidentiality may also be breached in the event there is an emergency where protection of an individual or yourself is necessary. North Carolina law requires report of both child abuse or elder abuse and your counselor does not need a Release to speak to authorities in these cases. If it is your wish that your counselor communicate with a third party, or you request a transfer or release of you records, you will be asked to sign a release form. In addition, you will be provided a copy of HIPPA regulations. These have been put into place to protect your client data due to increased use of electronic technology. Also, if I see you in public outside the office, I do not approach you for confidentiality purposes. If however, you choose to approach me I will interpret that as your being comfortable with the situation. I will still keep our “relationship” status confidential to the best of my ability. I do not accept friend requests or converse with my patients on personal social media of any kind for confidentiality purposes.

Correspondence, Consultations, Copies and Reports:

Phone calls, email correspondence, consultations and reports are not counseling services and are therefore not reimbursable via insurance. Each report generated will require a $25.00-$50.00 payment and must be paid before a report will be generated or released. Phone calls, email correspondence and consultations will require a $2.00 minute fee and must be paid at time of service or at your next session. A photocopy fee of $.50 per page applies and must be picked up at the office, allowing a one week turnaround period. Release of records form must be signed by patient/guardian and fee must be paid at

the time of request. All requests must be made in writing. I do not advocate for clients via the court system for any reason.

Complaint Procedures
If you are dissatisfied with any aspect of our work, this is most effectively and productively dealt with in our sessions together. Please feel free to ask any questions or clarify any confusion you may have about our work. In the event that you have a complaint against your counselor and it cannot be rectified with your counselor first, you may contact the North Carolina Board of Licensed Professional Counselors at; NC Board of Licensed Professional Counselors P.O. Box 77819, Greensboro NC, 27417

Please read carefully and complete the following section:

- I have read these policies and understand and accept them as described.
- I hereby give my permission and consent to Diane Myers to provide psychotherapeutic treatment to me and/or _____ who is (are) my spouse/child(ren).
- I understand that I need to give 24 hours' notice of an appointment change so as not to be charged a 50.00 fee on the card given on the date of the original appointment.
- I will pay $100 per session, unless otherwise agreed upon with the therapist.

Client's Signature _____ Date _____

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____

Authorization for Release and

Exchange of Information Form

I hereby authorize the release and exchange of information specified below between Diane Myers LCMHC of LifeCare Counseling and Coaching:

Name: _____

Address: _____

Phone: _____ Fax: _____

This release of information is required for the following purpose(s):

- Coordination of care
- Other _____

And shall be limited to the following specific types of information:

- All information in client's file
- Progress Notes
- Diagnosis Code(s)
- Treatment Plan/Goals
- Summary of Counseling Sessions Only

Other: _____

Method of Disclosure:

- Written
- Verbal
- Electronic

This authorization for release is made with informed consent and this consent is subject to revocation by written instructions of the undersigned at any time. Further, I understand that this consent shall expire and must, if needed, be re-obtained six (6) months from the date below.

Client Name (print):_____

Client Signature: _____

Date: _____

I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Client Demographics

Date:_____

Name: _____
(Last) (First) (Middle Initial)

DOB: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Address:
_____
_____
_____
_____

Client Preferred Method of Contact: Cell Phone □ E-mail □

Cell Phone:_____

May we leave a message? □ Yes □ No

Email: _____May we email you? □ Yes □ No
*Please note: Email and/or text or cell phone correspondence is not considered to be a confidential medium of communication.

Name of parent/guardian (if under 18 years):

_____

Legal Guardian's Email &/Or Phone:_____

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Employment Status: _____ Unemployed _____Full Time _____Part Time _____Disabled

_____Retired ___Student: if so, do you live home?_____

Employer: _____

If seeking a sliding scale fee, please list annual income:_____

Please list any children/age: _____

Please describe in your own words the current problems as you see them: _____
_____
_____
_____
_____

How long has this been going on? _____

What made you decide to come in at this time? _____
_____

What do you hope to gain from this evaluation and/or counseling? What is your goal for attending counseling at this time? _____
_____
_____
_____
_____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

Reason for seeking help and dates of treatment: _____

Are you currently taking any prescription medication?

□ Yes

□ No

Please list: _____
_____
Dose: _____
Purpose: _____
How long have you been taking it: _____
Please list and provide dates: _____

_____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

□ Currently

Dose: _____

Purpose: _____

_____

How long have you been taking it: _____

Please list and provide dates: _____

–

_____

How effective was it: _____

Please describe any side effects you noticed: _____

_____

Are you currently under treatment for any medical condition?

□ No □ Yes

If yes please describe _____

_____

_____

How would you rate your overall current health?

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your overall current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your overall current exercise habits?

Poor Unsatisfactory Satisfactory Good Very Good

How many times per week do you engage in exercise _____

What types of exercise or physical/cardio exercise do you engage in

_____

_____

_____

1. Do you drink alcohol more than once a week? □ No □ Yes

   How much? _____

   How often? _____

   What was age of first use?_____

   Have you ever passed out from drinking? How often? _____

   Have you ever blacked out from drinking? How often? _____

   Have you ever had the shakes? How often? _____

   Have you ever felt you should cut down on your drug or alcohol use? _____

   Have people annoyed you by criticizing your drug or alcohol use? _____

   Have you ever felt bad or guilty about your drinking or drug use? _____

   Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover?

   _____

Do you use tobacco? If Yes, how often? _____

2. Do you engage in recreational drug use?

	□ Daily	□ Weekly	□ Monthly	□ Infrequently	□ Never
Marijuana □					
Cocaine □					
Crack □					
Heroin □					
Methamphetamine □					
Ecstasy □					
Other □					

What was your age at first use? _____
Time since last use? _____
Approximate use in last 30 days? _____
Is there anything else you would like us to know about? _____
_____
_____

3. Have you ever experienced the loss of a child through abortion or natural/ unnatural causes?
□ No □ Yes

4. Do you have any type of sexual abuse in your history either as a child or as an adult
□ No
□ Yes
□ Unsure

5. Have you ever attempted suicide?
□ No □ Yes

6. Has anyone you know ever completed suicide or attempted suicide?
□ No □ Yes

7. Please list any applicable prior illnesses, operations and/or accidents
_____
_____

8. During your childhood, did you live any significant period of time with anyone other than your biological parents? □ No □ Yes
What were their name(s) and Relationship to you? _____

9. What were your childhood relationships like within your family of origin?

Mother
_____

Father
_____

Siblings
_____

_____
_____
_____

Grandparents/Aunts/Uncles/Cousins

_____
_____
_____
_____

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

12. Do you identify with a religious affiliation: □ No □ Yes

Give a brief overview of your faith or beliefs: _____

13. Have you ever served in the Military, If Yes when? _____

14. Have you ever been arrested? Please explain: _____
_____

15. Who or what do you turn to for help?
Name:_____
Relationship to you: _____

16. Have you ever been abused?
□ Verbally □ Emotionally □ Physically □ Sexually □ Neglected
Please describe to the best of your ability and comfort level

_____
_____
_____

17. Sexual Preference: □ heterosexual □ homosexual □ bisexual □ other □ unsure

Please check the box of any symptoms or experiences that you have had in the ***last few months***

□ Difficulty concentrating or thinking
□ Nightmares
□ Flashbacks
□ Large gaps in memory
□ Thoughts about harming or killing someone else

□ Thoughts about harming or killing yourself

□ Difficulty falling asleep
□ Difficulty getting out of bed
□ Average hours of sleep nightly _____
□ Difficulty staying asleep
□ Not feeling well rested in the morning

□ Feeling as if you were outside yourself, detached, observing what you are doing
□ Feeling puzzled as to what is real and unreal
□ Persistent, repetitive, intrusive thoughts, impulses, or images
□ Unusual visual experiences such as flashes of light, shadows
□ Hear voices when no one else is present
□ Feeling that your thoughts are controlled or placed in your mind
□ Feeling that the television or the radio is communicating with you
□ Difficulty problem solving
□ Dependency on others
□ Inappropriate expression of anger
□ Difficulty or inability to say “no” to others
□ Sense of lack of control
□ Abusive relationship
□ Concerns about your sexuality
□ Difficulty meeting role expectations
□ Manipulation of others to fulfill your own desires
□ Self-mutilation or cutting
□ Ineffective communication
□ Decreased ability to handle stress
□ Difficulty expressing emotions

□ Persistent loss of interest in previously enjoyed activities
□ Withdrawing from other people
□ Depressed Mood
□ Rapid mood changes
□ Anxiety
□ Frequent feelings of guilt
□ Spending increased time alone
□ Feeling numb
□ Irritability
□ Chronic Pain
□ Panic attacks
□ Avoiding people, places, activities or specific things
□ Difficulty leaving your home
□ Fear of certain objects or situations (ie, flying, heights, bugs) Describe: _____
□ Repetitive behaviors or mental acts (ie, counting, checking doors, washing hands)
□ Outbursts of anger

□ Worthlessness
□ Sadness
□ Fear
□ Hopelessness
□ Helplessness

□ Feeling or acting like a different person

□ Changes in eating/appetite
□ Eating more
□ Eating less
□ Voluntary vomiting
□ Use of laxatives
□ Binge eating
□ Weight gain lbs _____
□ Excessive exercise to avoid weight gain
□ Are you trying to lose weight? _____

□ Difficulty catching your breath
□ Unusual sweating
□ Increased energy
□ Decreased energy
□ Increased muscle tension
□ Easily startled, feeling “jumpy”
□ Tremors
□ Dizziness
□ Frequent worry
□ Physical sensations others don’t have
□ Racing thoughts
□ Intrusive memories

ADDITIONAL INFORMATION:

If you are currently employed, do you enjoy your work?
Is there anything stressful about your current work?

_____

_____

_____

1. What do you consider to be some of your strengths?

_____

_____

_____

_____

2. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Psychiatric Hospitalization	yes/no	
Psychiatric Medications	yes/no	
Schizophrenia	yes/no	
Bipolar	yes/no	
Sexual Abuse	yes/no	
Suicide Attempts/Completions	yes/no	
Trauma or PTSD	yes/no	