GENERAL PERSONAL AND FAMILY BACKGROUND

Name _____ M/F__ Social Security # _____
Last First Middle
Birthdate _____ Age ___ School/Employer _____ Education Level _____

Name _____ M/F__ Social Security # _____
Last First Middle
Birthdate _____ Age ___ School/Employer _____ Education Level _____

Address _____
Street City State Zip

Home Telephone Number _____ **Cell Phone Number** _____

Children:

Name _____ M/F__ Social Security # _____
Last First Middle
Birthdate _____ Age ___ School/Employer _____ Education Level _____

Name _____ M/F__ Social Security # _____
Last First Middle
Birthdate _____ Age ___ School/Employer _____ Education Level _____

Name _____ M/F__ Social Security # _____
Last First Middle
Birthdate _____ Age ___ School/Employer _____ Education Level _____

Husband's Place of Employment _____ Phone _____
Wife's Place of Employment _____ Phone _____

Single [ ] Married [ ] Anniversary _____ Separated [ ] Divorced [ ]
Other [ ] (Explain) _____

Were you married before? Yes [ ] No [ ] If yes, please answer the following:

Who was married?	Dates	Reason marriage ended
	From_____ To_____	
	From_____ To_____	
	From_____ To_____	
	From_____ To_____	

RELIGIOUS AFFILIATION

Husband: _____ Active _____ Inactive _____

Wife: _____ Active _____ Inactive _____

Children: _____ Active _____ Inactive _____

HEALTH CARE INFORMATION

Your Primary Physicians: _____ When Last Seen/Reason for Visit: _____
Husband _____
Wife _____
Children _____

List any current health problems and/or medication:
Husband _____
_____
Wife _____
_____
Children _____
_____

PREVIOUS COUNSELING

List all previous professional help you have received for personal, marital, or family concerns:

Name	Date	Therapist	Reason
	From_____ To_____		
	From_____ To_____		
	From_____ To_____		

Referral Source _____

Type of therapy requested: Family_____ Couple_____ Individual_____

Please describe reason for which you are seeking counseling, and add any additional information which you feel may be useful to us:

_____

_____

_____

_____

_____

By signing below, I affirm that the information given above is true and correct. I am also signifying that I have read, understand and am receiving a copy of the documents:

RIGHTS AS A THERAPY CLIENT UNDER HIPAA
NOTICE OF PRIVACY PRACTICES OF SOUTHEASTERN COUNSELING CENTER

_____
Signature Date

_____
Signature Date

NOTICE OF PRIVACY PRACTICES
OF
SOUTHEASTERN COUNSELING CENTER

THIS NOTICE DESCRIBES HOW WE USE YOUR HEALTH INFORMATION, HOW WE MAY SHARE IT WITH OTHERS, AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. We will use the information you share in therapy, as well as information from other such as physicians, other counselors, social workers, etc., to provide you with treatment.

We protect your information in several ways. All counselors, interns, supervisors, and staff are required to sign confidentiality agreements promising not to look at or disclose clinical information except as a part of their regular duties. All therapy files and client information are stored in locked offices. In consultation with other professionals, all counselors, and supervisors release only the minimum necessary information.

Examples of ways we share a client's personal information may include: consultation with other professionals such as physicians, attorneys, social workers, etc.; supervision of therapy interns, and billing to third-party payers. In order for us to disclose your personal information we must have the signed consent of each person eighteen years of age or older, who participates in therapy. Exceptions to the requirement of a signed release are listed in the 'Counseling Agreement' document.

You have certain rights regarding your personal health information. Those rights are specified in the 'Rights of a Therapy Client Under HIPAA' document.

If you have any questions regarding this notice or your rights under HIPAA, please contact the Director of the Counseling Center.

HEALTH INSURANCE PORTABILITY AAND ACCOUNTABILITY ACT OF 1996 (HIPAA)

RIGHTS AS A THERAPY CLIENT UNDER HIPAA

1. As a client, you have the right to see your therapy records. However, any psychotherapy notes the counselor may keep for his/her own use in your treatment are afforded special privacy protection under the HIPAA regulations and are excluded from this right.

2. As a client, you have the right to receive a copy of your therapy records. You may be required to pay for copying fees for this information should you choose to receive a copy. However, any psychotherapy notes the counselor may keep for his/her own use in your treatment are afforded special privacy protection under the HIPAA regulations and are excluded from this right.

3. As a client, you have the right to request amendments to your therapy records. That request must be made in writing and be directed to the Director of the Counseling Center.

4. As a client, you have the right to restrict the use and the disclosure of your protected health information for the purposes of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign an authorization form detailing exactly to whom and what information you wish to be disclosed.

5. As a client, you have the right to register a complaint with the Director of the Counseling Center and the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

CLIENT RELEASE FORM

Therapy release for consultation:
You, the client, may be seeing a marriage and family therapist-intern, a professional counselor-intern, or a social worker intern, under the direct supervision of a licensed supervisor or supervisor-in-training with the Southeastern Counseling Center. This intern may request professional consultation from time to time, to provide you with the most competent care possible. By signing below, you understand that you may be seeing one of the above mentioned interns under direct supervision, and that the supervisors are bound by the same ethics and confidentiality guidelines of this agency as the intern.

_____

Client signature Date

Release for video tape and viewing of therapy session(s):
Southeastern Counseling Center will capture sessions on video (not audio) for the protection of the client and therapist. By signing below you acknowledge that you are aware of the video and understand that the video is covered under the same ethics and confidentiality guidelines of this agency and as allowed by South Carolina state law.

_____

Client signature Date

southeastern counseling center

P.O. Box 339, 115 Children's Way, Duncan, SC 29334 · (864) 439-0259 · www.sech.org

COUNSELING AGREEMENT

I understand that I am entering into a therapeutic counseling relationship with Southeastern Counseling Center. I understand that I have the right to terminate this relationship upon due notice to Southeastern Counseling Center.

I also understand that all fees for services rendered are due at the time they are given unless previous arrangements have been made. I understand that failure to cancel a scheduled appointment twenty-four hours in advance may result in a full fee charge for that session.

I understand that I may be seeing a marriage and family therapist-intern, a professional counselor-intern, or a social work intern, under the direct supervision of a licensed supervisor or supervisor-in-training with the Southeastern Counseling Center. This intern may request professional consultation from time to time, to provide you with the most competent care possible. I also understand that all of the counselors at Southeastern Counseling Center have the right to consult among themselves as to my services and care, but they can not divulge information concerning me or my case outside of the center without my prior written consent.

I further understand that this agreement covers me and any minor children which I may include in therapy.

Exceptions to Confidentiality (Duty to Warn):
Although shared personal information is confidential, there are exceptions to these confidences such as:

1. Suicidal threats or attempts
2. To prevent a clear and immediate danger to yourself or another person
3. Suspected child abuse or neglect
4. Suspected abuse or neglect of a vulnerable adult
5. A subpoena issued by a court of law or to report what is required by a court order or in order to defend myself against charges arising from therapy
6. Otherwise mandated or allowed by law or ethical codes for which I am responsible

THESE EXCEPTIONS REQUIRE THE COUNSELOR OR INTERN TO NOTIFY THE APPROPRIATE AUTHORITIES.

I HAVE READ AND UNDERSTAND THAT ABOVE INFORMATION AND GIVE CONSENT FOR TREATMENT.

Signature	Date
Signature	Date
Counselor	Date

southeastern counseling center
P.O. Box 339, 115 Children's Way, Duncan, SC 29334 · (864) 439-0259 · www.sech.org

CANCELLATION POLICY

I understand that all appointments are made in good faith that I will attend and are set aside specifically for me. As such, any cancellations of appointments are required to be made 24-hours in advance to allow the time to be used if needed.

Additionally, to be fair to the therapeutic process, any client that arrives 15 minutes past the start of the session time will not be seen and must reschedule.

Any appointments not cancelled in advance or are considered "no shows" are subject to be charged at the full agreed upon rate of the session.

_____	_____
Client	Date
_____	_____
Therapist	Date

where the heart is

p.o. box 339 • 115 children's way • duncan, sc 29334 • phone: 864.439.0259 • fax: 864.949.0248 • sech.org

Dear Client,

You will be meeting with Dr. Clyde Mayberry for counseling.
He has his doctorate degree in family therapy and his masters in marriage and family therapy, but he does not yet have his license in South Carolina.
He works under the supervision of a license counselor and we wanted you to be aware of this before your session starts.

_____

Please sign acknowledging receipt

southeastern children's home

STANDARD SLIDING SCALE (November 2018)

Number in the Household	1-2		3+	
Total household income before taxes	Intake	Regular	Intake	Regular
$0 to $19,999	$75	$40	$65	$30
$20k to $29,999	$85	$50	$75	$40
$30k to $39,999	$95	$60	$85	$50
$40k to $49,999	$105	$70	$95	$60
$50k to $59,999	$115	$80	$105	$70
$60k to $69,999	$125	$90	$115	$80
$70k to $79,999	$135	$100	$125	$90
$80k and up	$145	$110	$135	$100

1) A sliding-fee scale is offered based upon gross household income and # of people living in the household.
2) Our "usual & customary fee" also applies to clients who choose not to provide gross household income information.
3) Fees are expected to be paid at the time of service.
4) A written application plus tax return and/or recent paystubs may be submitted for further hardship consideration (i.e. an adjusted fee).

Call (864)439-0259 to get started today!
115 Children's Way
Duncan, SC 29334