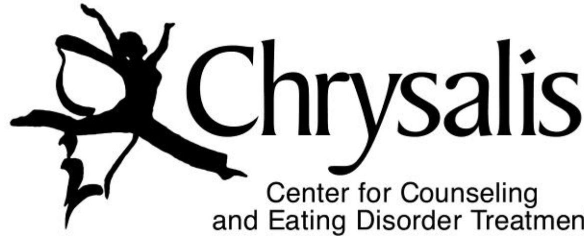

CONFIDENTIAL CLIENT INFORMATION

Welcome to the Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal law, any information you provide is strictly confidential.

Demographic Information:

Name ____ SSN _____________ Date ___________________

Mailing Address: ____

____

City: _________________________________ State ______________ Zip Code ________________

Email Address: ____

Home Phone: ___________________ Work Phone ___________________ Cell Phone: ____________________

What is the best way to contact you? __________________ Is it okay to leave a message? Yes No

___________________ _______ _______ ___________________ ___________________

Date of Birth Age Sex Ethnic Group Religious Preference

Relationship Status:

Single ____ Cohabitating ____ Married ____ Separated ____ Divorced ____ Widowed ____

Emergency Contact: ____ Telephone: (____) __________________

Parent/Guardian (if relevant): Name: ____

Address: ____ Telephone: (____) ________________

Referral Information:
How did you find out about our services? ____

Employment Information:
Are you currently employed? Yes No

If yes, where are you employed? ____

What is your job title? ____

For Office Use Only: Date of Last Information Update and Initials of Staff Member Completing

Education Information:
Highest Level of Education Completed:
Grade School ____ High School ___ College ___ Graduate School ____

Are you currently a student? Yes No
If yes, where? ________________________________ Year ______________ Major _________________________

Family/Significant Others:
Does anyone in your family have a history of the following? (please check all that apply)
Mental Illness ___ Substance Abuse ___ Eating Disorder ____ Obesity ______ Dieting ____
Please specify on the chart below:
Please provide the following information about your family members (include parents, stepparents, all siblings, spouse/partner, children, etc.) and significant others.

Name	Relationship to You	Age	Job/ Highest Education Completed	Where He/She Lives	Mental/Medical Conditions

Health Information:

Please list any chronic illnesses, injuries, physical conditions or disabilities:________________________________
____
____
____

Allergies/Adverse Reactions to Treatment:____
____

Primary Care Physician Name: ____

Address: ____ Telephone: (____) __________________
____

Current Medications Supplements & Vitamins	Daily Dose	Start Date	Name of Prescriber

Mental Health History:

Have you received counseling before? Yes No

If yes, when, where, and with whom? ____

____

Please list any hospitalizations for psychological, psychiatric, or chemical dependency treatment, including location and dates: ____

____

Have you ever experienced any of the following (check all that apply)?

Physical Abuse___ Sexual Abuse ___ Sexual Assault ____Verbal/Emotional Abuse ___

Have you experienced any recent and/or important loss? Yes No

If "yes", please specify ____

Is there any other relevant information that we have not asked about?

____

Clinical Information:

What type of services are you seeking/expecting? (Please check all that apply to you)

Individual Counseling ____ Group Counseling ___ Couples/Family Counseling ____

Bariatric Evaluation___ Assessment___ Nutritional Counseling ____

How well are you getting along psychologically at this time?

___ Very well, the way I want to.

___ Quite well, no important complaints.

___ Fairly well, but have ups and downs.

___ So-so, can keep going with effort.

___ Quite poorly, can barely manage.

___ Very poorly, don't think I can manage.

Current Issues (Please check all that apply to you):

___Romantic Relationships

___Family Relationships

___Peer Relationships

___Divorce/Separation

___Stress

___Depression

___Loneliness/Social Isolation

___ Sleep Problems

___Anxiety

___Fears/Phobia

___Unwanted Habits

___Legal Problems

___Financial Problems

___Career Planning

___Unemployment

___Academic Performance

___Learning Disabilities

___Attention Problems

___Self-Confidence/Self-Esteem

___Body Image

___Eating Disorder/Eating Issues

___Drug/Alcohol Abuse

___Physical Abuse

___Sexual Abuse/Molestation

___Sexual Assault

___Sexual Identity Issues

___Anger Management

___Homicidal Feelings

___Suicidal Feelings

___Racial/Cultural Issues

___Grief/Loss

___Physical Health

___Pregnancy (past, present)

___Spirituality

___Decision Making

___Other ______________________________

In your own words, please identify the concern(s) that you want to address in counseling. Be as specific as you can.

Chrysalis
Center for Counseling
and Eating Disorder Treatment

SYMPTOM CHECKLIST

Client Name: ______________________________ Age: __________ Date: ______________

Instructions: *Please answer the following questions by putting a check in the appropriate column or writing in a response where indicated.*

Symptom Experienced	**Y**	**N**	**N/A**
1. Has heavy drug or alcohol use ever caused problems in your life?			
Has anyone ever remarked on or expressed concern about your use of alcohol or drugs?			
Has heavy drug or alcohol use been a problem for you in the past year?			
Have you ever used marijuana, coke, heroin, or any other drug to make yourself feel good?			
2. Have you ever felt unusually high, charged up, excited or restless?			
Have other people ever said that you were too high, charged up, excitable, or talkative?			
How long have these moods usually last?			
What is the longest they have lasted?			
3. Have you ever felt depressed, sad, empty, or hopeless for several days or weeks at a time?			
Have you ever felt very irritable or tired for a period of time for no particular reason?			
How long do these feelings usually last?			
What is the longest they have ever lasted?			
4. Have you ever had sudden spells of nervousness, panic, or fear come over you for no particular reason?			
Did you see a doctor because of this?			
What did the doctor tell you about these symptoms?			
5. Have you ever very afraid of certain things, like heights, animals, needles, the sight of blood, lightening, etc?			
What were you afraid of?			
Have you ever been so afraid to leave home by yourself that you wouldn't go out?			
Have you ever been afraid to go to supermarkets, go into tunnels, or use elevators?			
Have you ever been so afraid of embarrassing yourself in public that you would not do certain things like eating in a restaurant, using a public restroom, or speaking out in a room full of people?			
6. Have you ever been bothered by certain embarrassing, scary, or ridiculous thoughts that came into your mind over and over again, even if you tried to ignore or stop them?			
Please describe them:			
7. Have you ever felt compelled to repeat a certain act (such as checking, counting, cleaning, ordering), follow particular routines or rituals, or do things in an exact way or order even if it didn't make sense?			
8. Have you ever experienced flashbacks, in which you found yourself reliving some terrible experience over and over?			
9. Have there ever been days at a time when you felt extremely nervous, anxious, or tense for no particular reason?			
Have you sometimes felt this way even if you had nothing special to do?			
Have these feelings ever bothered you on and off for six months or more at a time?			

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Symptom Experienced	Y	N	N/A
10. Have you consistently had difficulty focusing and paying attention?			
Do you frequently feel impatient, restless, and have difficulty sitting still?			
Would others describe you as impulsive and/or hyper (e.g. do you tend to blurt out comments, interrupt others, say or do things you regret later)?			
11. Have you had a lot of physical problems that have forced you to see different doctors?			
Have doctors had difficulty finding what caused the problems?			
Did you start having any of these problems before you were 30 years old?			
12. Have you ever deliberately lost so much weight that people expressed concern?			
Have you ever been afraid of getting fat even when other people said you were thin enough or too thin?			
13. Have you ever eaten so much that you felt sick?			
Have you ever eaten to comfort, soothe, reward, or punish yourself?			
Have you ever felt that your eating was excessive and/or not really normal?			
Have you ever felt out of control while eating?			
Have you ever felt depressed, ashamed, or disgusted after eating?			
Have you ever vomited, used laxatives or diuretics, or exercised excessively to try to make up for eating too much?			
14. In the past couple of months, have you been very worried or upset about something that happened to you, such as the death of a loved one, losing a job, getting separated or divorced, having a bad accident, getting a serious illness, etc?			
Do you feel that you've had more trouble handling this situation than most people would?			

15. Have any of these symptoms -- drinking, drug use, moods, anxiety, etc – ever interfered with school, work, or your job? What concerns, if any, have family and friends expressed? Please explain.

16. Have any of these symptoms ever gotten you into trouble with the authorities and/or caused legal problems? If yes, please explain.

17. Has your health ever suffered as a result of any of these symptoms? If yes, please explain.

18. Have you ever received medication or treatment for any of these symptoms? If yes, please explain.

19. Were you ever hospitalized for any of these symptoms? If yes, please explain.

Chrysalis
Center for Counseling and Eating Disorder Treatment

EATING AND BODY IMAGE CHECK SHEET

Client Name: ____ Date: ________________________________

Weight History:
Current Height _____ Current Weight _____ Desired Weight _____
Lowest Weight _____ Highest Weight _____ How often do you weigh yourself? ________

Food History:

Restrictive Eating/Dieting (please check all that apply)

	Past	Current		Past	Current
skipping meals	_____	_____	fasting	_____	_____
reducing portions	_____	_____	reducing calories	_____	_____
restricting carbs	_____	_____	restricting fats	_____	_____
restricting protein	_____	_____	restricting dairy	_____	_____
chewing & spitting	_____	_____	throwing away food	_____	_____

Binging/Compulsive Eating (please check all that apply)

	Past	Current		Past	Current
eating sweets	_____	_____	eating a lot in a short period of time	_____	_____
eating carbs	_____	_____	feeling out of control when eating	_____	_____
eating dairy	_____	_____	eating until uncomfortably full	_____	_____
eating to soothe self	_____	_____	guilt/shame after eating	_____	_____
eating to punish self	_____	_____	eating for emotional reasons	_____	_____

Specify binge foods____

Purging/Weight Control Measures:

Behaviors	# of times per day	# of days per week	Past or Present?
Vomiting	_____	_____	___________
	# of pills per day	# of days per week	Past or Present?
Diet Pills	_____	_____	___________
Laxatives	_____	_____	___________
Diuretics	_____	_____	___________
	# of mins per day	# of days per week	Type & Duration
Current Exercise	_____	_____	______________________________
Past Exercise	______	_____	______________________________

Possible contributors to eating & body image issues (check all that apply):

______ teasing about appearance
______ problems at school/work
______ media influences_
______ family problems
______ puberty
______ medical reasons (illness/operation)
______ depression
______ death/loss
______divorce
______ difficulty coping with stress
______ relationship issues
______ leaving home/separation
______ difficult sexual experience
______ prolonged period of dieting
______ body image dissatisfaction
______ problems w/friends

recommendation of weight loss by: _______ parent ______ friend ______ physician ______ coach
other (please explain)____

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EATING AND BODY IMAGE CHECK SHEET

Physical Symptoms:

Which of the following are you currently experiencing?

______ loss of period
______ irregular period
______ nausea
______ dizziness
______ light-headedness
______ fainting spells
______ weakness
______ fatigue
______ lack of energy
______ sleep problems
______ acid reflux
______ indigestion
______ gas
______ cramps

______ bloating
______ diarrhea
______ sore throat
______ swollen glands
______ ulcers
______ dental problems
______ irritated gums
______ chest pain
______ irregular heartbeat
______ shortness of breath
______ frequent urination
______ dehydration
______ water retention
______ excessive thirst

______ brittle hair
______ hair loss
______ dry skin
______ yellowish skin
______ coldness
______ muscle cramps
______ muscle weakness
______ loss of muscle
______ tingling
______ numbness
______ swelling of ankles
______ swelling of hands
______ fractures
______ injuries

other: ____

Last physical exam: when, where & with whom? ______________________________

Psychological Symptoms:

Which of the following have you experienced?

______ irritability
______ depression
______ mood swings
______ mania/high mood
______ guilt
______ worthlessness
______ hopelessness
______ perfectionism
______ obsessive thoughts
______ following strict routines/rigid rules
______ engaging in rituals

______ difficulty making decisions
______ impaired concentration
______ memory problems
______ phobias
______ panic attacks
______ avoidance of social situations
______ fear of sex
______ promiscuous sexual behavior
______ risky sexual behaviors
______ thoughts of suicide
______ self-mutilation (cutting, burning, hurting)

Substance Use:

Which of the following substances do you use? Specify amount & frequency of use.

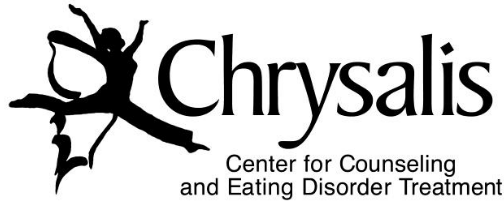
__caffeine ____
__cigarettes ____
__alcohol ____
__drugs (what kind?) _____________________________________

Who knows about your eating disorder? ______________________________

Other questions or concerns that have not been specifically addressed:

____

____



RIGHTS & CONSENT TO TREATMENT

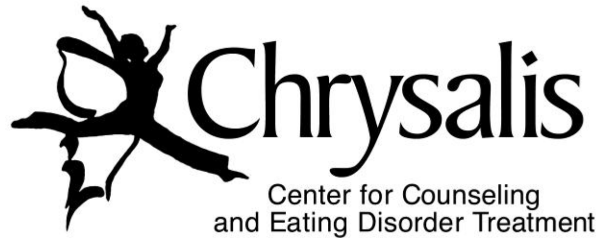
- ❑ You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- ❑ You have the right to be treated in accordance with professional and ethical standards of conduct.
- ❑ You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Clinical records will be maintained in a secure, locked environment. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order.
- ❑ You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- ❑ I understand that sessions run for 45-50 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- ❑ I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- ❑ I understand that there is no guarantee that any particular outcome will result from treatment.
- ❑ I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians, Kelly Broadwater, LPA, LPC, Kim Longbottom, LCSW, LCAS, Annmarie Miller, LCSW, Ashley Swinson, LCSW, and Kendra Wilson, LCSW and the nutritionists, Chaundra Klein, RD, LDN and Terri Mozingo, RD, LDN actively collaborate and consult about mutual cases, as well as share clinical notes.
- ❑ I understand that my therapist may consult and share clinical information with their supervisor and/or clinical board in order to provide legal and ethical treatment. They may also do so to meet the requirements set forth for their licensure or certification.

I have read and understood this document and will address any concerns or questions with my therapist and/or the office manager.

Client/Representative Signature ____ **Date** ________________

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature ____ **Date** ________________



Office Procedures and Financial Agreement

Please read, initial, and sign below. You may request a copy for your records.

Chrysalis is a business facility where a number of mental health professionals practice. Your contract for services is with our facility and applies to any and all providers you may see here.

APPOINTMENTS:

All office visits are by appointment and may be scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. The usual length of an appointment is 45-50 minutes. If you arrive more than 15 minutes late, you may be asked to reschedule your appointment, which will result in a *late cancellation* charge.

Payment: Payment is required at the time services are rendered, whether you are a self-pay client or have insurance benefits. Please note: if you are unable to provide payment at the time of service, you will not be seen and your appointment will be considered a *late cancellation*. You will be charged for the appointment time. Acceptable methods of payment include cash, check, and credit card. *The fee for returned checks is $35. If a second check is returned, you will be asked to arrange another method of payment.*

Late cancellations/No shows: For a missed or late cancelled clinical or nutritional appointment, you will be charged the *self-pay* rate for the appointment (unless otherwise specified by your insurance carrier). Please note: both clinical and nutritional appointments must be cancelled by 9:00am the business day before. Please be advised that reminder calls are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

INSURANCE:

Insurance co-payments are due at the time of service. If your insurance deductible has not yet been met, you will be billed the full charge for services. As a courtesy to you, we will bill rendered services to your insurance carrier. We cannot guarantee insurance coverage, nor that the information provided by your carrier is accurate. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. *It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility.*

Please note: treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers, may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

Medicaid/Medicare: Co-payments are due at the time of service. You are also required to present your Medicaid or Medicare Card at each visit. Failure to present your card may result in your not receiving services. If your Medicaid or Medicare coverage has lapsed or terminated, please be advised that you will be responsible for payment in full for services rendered during that time.

OUTSTANDING BALANCE:

You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued.

If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from

treatment, and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with the Office Manager or Accounts Receivable Manager.

Late Fees: A late fee of $25 will be charged to accounts that are not paid within 30 days of receipt of the first bill. If payment is not received by the third billing cycle, your delinquent account may be referred to collections and you will be responsible for all associated collections and fees.

ADDITIONAL SERVICES

In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring for psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment.

Phone Calls: Typically there is no charge for phone calls. However, phone calls that are extended and/or that constitute therapy may be billed at our self-pay rate.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do not reimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Case Management Fee: Extensive services that involve clinical coordination and continuity of care may constitute an additional fee that is separate of therapeutic services.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

______ I have read, understand, and agree to the above policies.

______ I have discussed these policies and addressed concerns and questions with the Office Manager or AR Manager.

______ I have been offered a copy of these policies to take with me if I desire.

______ I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.

______ I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

___________________________________ ________________

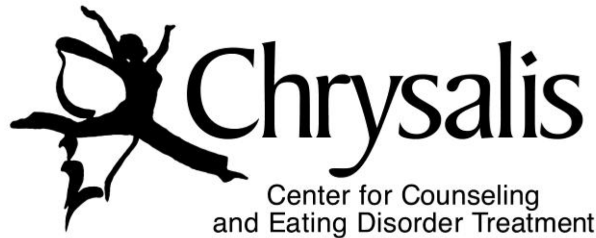
Signature of Client Date

___________________________________ ________________

Signature of parent or Legal Guardian Date

___________________________________ ________________

Signature of Office or AR Manager Date



**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): ______________________________

Address: ______________________________

Telephone: ______________________________

Birth Date: ______________________________

Social Security Number: ______________________________

Relationship to Policy Holder:______________________________

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): ______________________________

Policy Holder's Address: ______________________________

____

Policy Holder's Telephone: ______________________________

Policy Holder's Birth Date: ______________________________

Policy Holder's Social Security Number: ______________________________

Employer's Name: ______________________________

Insurance Plan Name: ______________________________

Subscriber Number or Member ID Number: ______________________________

Group Number: ______________________________

* Please see reverse side for secondary insurance information and consenting signature.

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): ______________________________

Policy Holder's Address: ______________________________

____

Policy Holder's Telephone: ______________________________

Policy Holder's Birth Date: ______________________________

Policy Holder's Social Security Number: ______________________________

Employer's Name: ______________________________

Insurance Plan Name: ______________________________

Subscriber Number or Member ID Number: ______________________________

Group Number: ______________________________

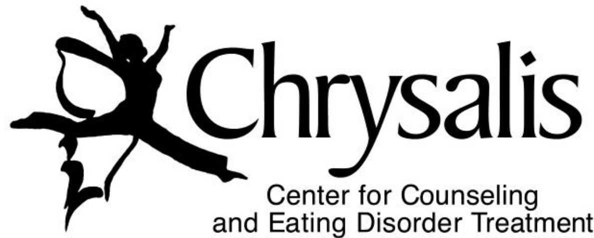
I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

______________________________ ______________________________

Name of Client (printed) Date

____

Signature



ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES & CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, ___________________________ and Chrysalis Center. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name(s) here ____.
When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form you are agreeing to let us use your information and send it to others. Please read the Notice of Privacy Practices dated 05.25.2010 before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.chrysaliscenter-nc.com, or by calling us at 910-790-9500. If you have any questions regarding the Notice or your privacy rights, you can also contact Kendra Wilson, LCSW, Privacy Officer, at kendra@chrysaliscenter-nc.com or at the address listed below.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to our Privacy Officer at Chrysalis Center about these concerns. (Although we will try to respect your wishes, we are not required to agree to these limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter to the Privacy Officer). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Chrysalis Center's Notice of Privacy Practices. My signature indicates that I have reviewed this notice and understand its content.

Signature: ____ Date: _______________

Printed Name: ____ Date of Birth: _______________

Relationship to Client (if guardian or representative):____

** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).*

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.
□ ***Client Refuses to Acknowledge Receipt***:
Signature of authorized representative of this office or practice: ____

Revised 07.14.2011