APPLICATION FOR SERVICE

Please complete the following information to better help your counselor assess your situation. The information will be kept confidential. If you are completing this as a parent or guardian of a prospective client, please give information pertaining to that person.

CLIENT INFORMATION

Today's Date:_____

Last Name:_____ First Name:_____ Date of Birth:_____ Current age:____

Address_____ Apt.____

City:_____ State:_____ Zip:_____

Highest grade/Degree completed:_____

Current Employer:_____

Home Phone:_____ Business Phone:_____

Home E-Mail:_____ Business E-Mail:_____

In case on an emergency please contact… If not employed, most recent employer:_____

Name:_____ ***For Clients under the age of 16:***

Home Phone:_____ Name of Parent/Guardian/Guarantor:_____

Work Phone:_____

MARITAL INFORMATION

Currently I am:	***If applicable, please give information about marriages:***	
☐ Single	**Current Spouse**:	**Previous Spouse:**
☐ Engaged	Name:_____ Date of Birth:_____	Name:_____ Date of Birth:_____
☐ Married	Year Married:_____	Year Married:_____
☐ Separated	Year Separated:_____	Year Separated:_____
☐ Divorced	Year Divorced:_____	Year Divorced:_____
☐ Widowed	Year Widowed:_____	Year Widowed:_____

FAMILY INFORMATION

Is your mother living? ☐Yes ☐No Is your father living? ☐Yes ☐No

Were you raised by anyone other than your biological parents? ☐Yes ☐No If Yes, by whom?_____

If applicable, please give information about your children:

1st child – Name:_____ Age:____
Adopted: ☐ Yes ☐ No Living: ☐ Yes ☐ No

2nd child – Name:_____ Age:____
Adopted: ☐ Yes ☐ No Living: ☐ Yes ☐ No

3rd child – Name:_____ Age:____
Adopted: ☐ Yes ☐ No Living: ☐ Yes ☐ No

4th child – Name:_____ Age:____
Adopted: ☐ Yes ☐ No Living: ☐ Yes ☐ No

MEDICAL INFORMATION

How would you describe your overall health?_____

Has there been any change in your weight in the past year? ☐ Yes ☐ No If yes, please explain:_____

Has there been any change in your sleep patterns in the past year? ☐ Yes ☐ No If yes, please explain:_____

Physician's Name:_____ Date and Report of last physical:_____

List any current medications, MG's, and for what purpose taken:

_____

_____

PREVIOUS COUNSELING INFORMATION

Have you had counseling in the past? ☐ Yes ☐ No

If yes, when?_____ Name of counselor/therapist:_____

For what purpose?

Ever diagnosed?

Would you be willing to sign a ***Release of Information*** form giving permission to obtain records from your previous counselor?

☐ Yes ☐ No

CURRENT NEED DESCRIPTION

Describe briefly the major concern that brings you for counseling at this moment:

Describe what you have done about this concern prior to this appointment:

Have you had any thoughts of hurting yourself or someone else? _____ If yes, please describe (how long ago, yourself or others, did you have a plan?)

- *I understand that because the counselor has reserved time exclusively for me, it is absolutely necessary that I notify my counselor at least 48 hours in advance if it is necessary to cancel my appointment. I understand that I will be charged my regular fee for "no show" or late cancellations with the exception of illness or emergencies.* ***Initial _____***
- *I have read the* ***STATEMENT OF DISCLOSURE*** *and have had an opportunity to ask any questions.* ***Initial _____***
- *This is to certify that I have read and understand the terms stated above and hereby consent to counseling in full accordance with these terms.* ***Initial _____***

(If under 16, must be signed by parent or legal guardian)

Signature:_____ Date:_____

Signature:_____ Date:_____

Access Counseling Group is a ministry of Access Christian Ministries, Inc.

Access Counseling Group (ACG)
Professional Disclosure and Informed Consent
Business Policy
Counseling Agreement

Amarie Lewinski, M.A., Licensed Professional Counselor

Before you start counseling there are some things that you ought to know. This document includes a Professional Disclosure Statement which is designed to inform you about Amarie Lewinski and to ensure that you understand the professional relationship. Another part of this document is the Informed Consent which will help you understand better what to expect from your effort at our office and it will explain some limitations to what we will be doing. Finally, this document includes the Business Policies of our office.

Professional Disclosure

DEGREES

B.A. Central State University, 1994, Edmond, OK
M.A. Gordon-Conwell Theological Seminary, 2006, Charlotte, NC

I have been counseling since 2004. I have been a Licensed Professional Counselor (LPC) since 2010.

PROFESSIONAL CREDENTIALS

Licensed Professional Counselor (LPC): North Carolina #7959
EMDR Trained Therapist (Eye Movement Desensitization and Reprocessing)

COUNSELING SERVICES OFFERED/THEORETICAL APPROACHES

People make better decisions if they have enough information and understand how something works. Therapy includes your active involvement as well as efforts to change your thoughts, feelings, and behaviors. You will have to work in and out of the counseling sessions. There are no instant, painless, or passive courses, no “magic pills”. Instead there will be homework assignments, exercises, and perhaps projects. Most likely, you will have to work on relationships and make short-term and long-term efforts, which sometimes may need to be repeated. At times, change will be easy and swift, but often it will be slow and deliberate.

You should know that counseling is not always easy. You may find yourself having to discuss very personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you might become somewhat depressed. Counseling is intended to alleviate problems, but sometimes, especially at first, and as you get to the root of some things, you may feel them even more acutely than in the past.

As with any powerful intervention, there are both benefits and risks. Risks might include experiencing uncomfortable levels of feelings like sadness, happiness, guilt, anxiety, anger, or frustration. Some changes may lead to what seems to be worsening circumstances or even losses (for example, counseling will not necessarily keep a marriage intact.)

We may also ask you to do some things that might, at first, make you feel awkward or uncomfortable. Sometimes counseling requires trying new ways of doing things. You will always be free to move at your own pace, however. We will challenge you and your old ways of thinking and doing things, but we cannot offer any promise about the results you will experience. Your outcome will depend upon many things.

My approach to therapy in helping people solve problems varies with the problems presented. I am eclectic in my style of therapy and implement a variety of psychotherapy orientations with clients. Each has its own strengths depending on what is best for the individual client at a given time. It is my intent to offer unconditional positive regard and empathy while offering insight to change through Cognitive-Behavioral, Emotionally Focused, EMDR, and Family Systems therapies.

I believe that the Bible is a remarkable guide for getting through life circumstances and when a client is open to Biblical principles, I take an integrated approach to counseling by blending Biblical principles with sound clinical insight from the study of psychology. However, these principles are never imposed on clients.

As we work together, the goal of therapy will need to be specified and I will create a treatment plan with you. That is, we will look at what you would like to change, what we will do to change it, how we will know you are succeeding, and how long it will take. Every now and again, we will review that plan to see if it needs to be updated.

If a diagnosis is necessary, it becomes a permanent part of your client record.

All first time appointments with your counselor are considered an evaluation. Follow up appointments will be determined after the end of your initial visit. I do not accept a client unless, in my professional opinion, I would be able to help that client by using the therapeutic methods I have available. Any issue that is deemed acute and needing attention of a specialist will be referred to an appropriate professional in the community. If I believe that your problems require knowledge that I do not have, I may refer you for a consultation with someone with specific training or experience. I will discuss any such referral with you before I act.

EXPLANATION OF DUAL RELATIONSHIPS

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. While I am seeing you for therapy, you will be best served if our relationship stays professional and that our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. It is important for you to remember that you are experiencing me in the professional relationship. Please do not invite me to friend you on Facebook, Tweet you on Twitter, to social gatherings, offer me gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions.

COMPLAINT PROCEDURES

If you are dissatisfied with any aspect of our work, please inform me immediately. You may contact me at 704-497-0225. Any complaint may be directed to the North Carolina Board of Licensed Professional Counselors at P.O. Box 1369, Garner, NC 27529.

BUSINESS POLICY

This Business Policy includes:

Fees and Length of Sessions
Payment Methods, Legal Related Services
Billing and Insurance Reimbursement
Telephone
Confidentiality

SCHEDULE OF FEES AND LENGTH OF SESSIONS

Fees are payable in full at each session. I prefer to tend to the business aspect of our time together at the beginning of each session. Please make checks payable to **"Access"**. This office **only** accepts check or cash. During the course of therapy it may become necessary to increase fees to compensate for increased costs and inflation. Fees will be reviewed periodically and will be increased no more than once during any calendar year.

Interview or Therapy Sessions

Psychotherapy Session **Individual** (approx. 45 minutes) Psychotherapy Session **Couples** (approx. 45 minutes)	$110.00 $125.00
Psychotherapy Session (5- 10 minutes)	$28.00
Psychotherapy Session (approx. 20-25 minutes)	$70.00
Psychotherapy Session (approx. 75 minutes)	$209.00
Psychotherapy Sessions **Individual** Psychotherapy Sessions **Couples** e.g. 2 sessions, 1 ½ hours = $220 e.g. 2 sessions, 1 ½ hours = $220 3 sessions, 2 ¼ hours = $330 3 sessions, 2 ¼ hours = $330 4 sessions, 3 hours = $440 4 sessions, 3 hours = $440 Additional 1/3 session, 15 minutes = $420 and 2/3 session, 30 minutes = $84	$110.00 Individual or $125.00 Couples per session rate each 45 minutes.
Testing An individual is charged for the time required to administer, score, interpret, and prepare the report.	Psychotherapy rates apply
Telephone Consultation (includes emergency telephone consultation but excludes scheduling or business administration calls)	$50 minimum Psychotherapy rates apply
Additional Consultation or Services performed on behalf of the Client	Psychotherapy rates apply **unless** it is legal services.
Other services (workshops, etc.)	Fees vary according to services.
***Any** legal related services (e.g. Quash a subpoena in 3 hours ($125 x 4 x 5 = $2500)	5 times session rate ($650 each 45 minutes), + expenses, + travel time to and from office

*The focus of this practice is to help people work on their therapy and **NOT DO** legally related services. You can be referred to another therapist, e.g. a forensic psychologist, or an attorney for legally related services.

LATE CANCELLATIONS OR MISSED APPOINTMENTS

If you are unable to keep an appointment kindly give 48 hours notice, otherwise charges will be made for the full time reserved in your behalf.

SEPERATION & DIVORCE POLICY

In separated or divorced families, the person who initiates the services is held financially responsible. Another person or an estranged spouse is not billed unless that individual informs us in writing of his or her willingness to pay for services rendered.

PAYMENT

Payment for all services is due at each session. Final payment is to be paid on behalf of the client before reports are released.

INSURANCE REIMBURSEMENT

Services provided by ACG are covered under some health insurance policies. However, most insurance companies reimburse mental health services at a different rate from other medical services. Most policies have annual deductibles and may set limits in dollars and the number of sessions allowed per year. Since benefits are so varied, it is wise to review your own policy carefully for coverage and any limitations. The receipt/statement given to you has all the information that should be necessary for insurance claims; **you are responsible for payment of your balance and the filing of any insurance claims.** Simply attach the ACG receipt to your claim form and submit it directly to your insurance carrier. As a business practice, ACG does not released our federal ID number to insurance companies or clients, because the payee of the insurance check is the client and **not** ACG.

TELEPHONE & ELECTRONIC COMMUNICATION

Our telephone is answered twenty-four hours a day by a digital answering system. Through the day, we check messages regularly, and whenever possible we try to return phone calls the same day. If we have not returned your call within forty-eight (48) hours, please try us again as your message may have been lost. We do not check office messages after 6:30 p.m. on weekdays, or routinely on weekends. If you have an emergency after 6:30 p.m. or on a weekend, call 911, or go to an emergency room.

When we are out of the office for several days, the messages you leave may be answered by another counselor. We will probably not have discussed your case with that person, but he or she will make every effort to be helpful to you in our absence. If we have another professional taking calls while we are away, please realize that we have confidence that the professional is properly trained to be helpful to you. To the extent possible we will keep you informed about when we are away from the office and when we will return.

It is important to understand that **cell phone, email and text messaging are not preferred forums for communicating information** to your counselor, for we cannot guarantee your confidentiality and security.

By signing this Disclosure Statement, you acknowledge that you have been informed of this policy and that if you choose to contact us through email or texts and wait for a response, you do so at your own risk and agree to hold Access Christian Ministries, Inc., Access Counseling Group, and its employees harmless for complications that may arise indirectly or directly.

CONFIDENTIALITY

Of course, all of our work together – our conversations, your records, and any information that you give us – is protected by something called *privilege*. That means that the law protects you from having information about you given to anyone without your awareness and permission. Our office respects your privacy, and we intend to honor your *privilege*. However, there are some limits to your privilege, some legal exceptions you should understand before we start.

To provide you with the best care possible, other professionals are consulted when clinically advisable. The confidentiality of the work that is done with you as a client is upheld at all times. However, there are certain exceptions to this rule:

1. If the therapist believes there is a risk that you might harm yourself or someone else, we may be required to contact the authorities or the other person to give them the opportunity to protect you or the other person.
2. If the therapist has cause to believe that you are abusing children or elderly or disabled people, we are required by law to notify authorities.
3. If you become involved in any lawsuit in which your mental health is an issue – for example, a child custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering – then the court or the lawyers may insist upon, and may obtain your information from us. Similarly, you would lose the protection of your privilege if you file a lawsuit against our office or a complaint with the state licensing board.
4. The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. If we find ourselves in a dispute with you over billing, our office may provide the collection company with information necessary to collect any outstanding balance.

COUNSELING AGREEMENT

This agreement for services will remain effective until _____, or until ended by agreement between you and your counselor. If you have missed a scheduled visit, and you do not call our office within seven (7) days, your counselor will accept that as your notice that you have terminated this agreement and that you wish to discontinue counseling with our office.

I/we have read the Professional Disclosure Statement (pages 1-2), the Business Policy (pages 3-4), and accept the policies described.

I/we understand that I/we am/are financially responsible for services rendered and that my/our account is due in full at each session. I/we understand that ACG does **not** accept assignments of benefits from insurance carriers.

I/we understand that I/we will be charged for the **full** time reserved in my/our behalf, should I/we miss an appointment or not provide a **48 (forty-eight)** hours notice of cancellation of an appointment.

I/we also understand that there is a $40.00 service charge for each returned check.

I/we hereby grant my/our permission for any therapy, testing, or diagnostic evaluation that may be deemed pertinent in the counseling of myself/ourselves, my/our marriage, or my/our family. I/we authorize the release of any therapy information necessary to process insurance claims for my/our treatment, and the release of the therapy sessions information with other therapy personnel. The therapy sessions and records are strictly confidential except where state law requires the reporting of threats of violence, harm, or child abuse and neglect (from evidence or suspicion), and when information is subpoenaed by the courts. Any request for the disclosure of your therapy records by a third party (other than by reason of a court issued Subpoena) will require a written authorization signed by you pursuant to a format that is in compliance with HIPPA regulations.

Being aware that there may be a potential for emotional strains, stresses, and life changes as a result of therapy, I/we agree to enter the therapy process. I/we understand that ACG and Amarie Lewinski are **not** an emergency service and does not guarantee any particular results or outcome from the therapy process.

If you have any questions, feel free to ask. Please print a copy of this form and sign/date the "Signature Page" of this document as well as initialing each page at the bottom right corner (gray box is for therapist initials). I will return this copy of the professional disclosure and will retain the "Signature Page" in my confidential records.
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Access
Counseling Group
Romans 5:2

Signature Page

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Signature of Parent/Legal Guardian (if applicable) Date

_____ _____
Therapist Date