Thank you for choosing Zola Counseling, PLLC to meet your mental health needs. We are very pleased to welcome you and to let you know that the practice here will do everything we can to make sure your needs are met and your concerns addressed.

You can expect to be treated with respect and dignity by all Zola Counseling therapists. We strive to provide the highest quality care possible and encourage you to let us know if you are not satisfied with your services or have any concerns or suggestions about your treatment. We want to always ensure that you are an active participant in the services you receive from our practice, and quality services depend on the close working relationship between your therapist and yourself. As a client, you have certain responsibilities and one is to actively participate in treatment and helping to develop your plan of care with your therapist, in order to ensure that the service remains centered on your needs and goals. This also requires regular attendance for your treatment sessions and to cancel your appointments as soon as you know you will be unable to attend them; in return, our team will also ensure that we keep our scheduled appointments with you, and contact you in advance of a session should a scheduling conflict arise.

One of our core values is to respect the rights and dignity of our clients and to create an environment of recovery. Consistent with this value, we want to be able to consistently receive and share feedback with you about the services you are receiving from our agency, and how we might all be able to best work together. Please communicate with us during treatment about how we can ensure we are all collaborating to get your needs met.

In order to ensure we maintain good communication at all times during the program, please always make sure we have the most current phone number by which we can contact you. In addition, here are some phone numbers for your reference:

Therapist Name: Rebekah Talley
Phone Number: 980-428-6195
Fax Number: 704-220-2366
Therapist Email: rebekahtalley@zolacounseling.com

After-hours/weekend On-Call for Mental Health emergencies: Contact the Cardinal Innovations Healthcare Solutions 24 hour, toll-free number at 1.800.939.5911, mobile crisis at 704-566-3410, or 911 for true medical emergencies.

Again, welcome to our practice. We look forward to working with you.

Zola Counseling, PLLC

Date: _____

Client Information
Name: Last_____ First _____ Middle _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home _____ Cell _____ Work _____
Where can we leave a message? _____
Email Address: _____
Is it ok to send you email reminders about upcoming appointments? Yes No
Date of Birth: _____ Social Security Number _____-_____-_____
Marital Status: _____ Employer: _____
Occupation: _____
How did you hear about us? _____

(If Minor)
Parent(s)/Legal Guardian: _____
Legal Custody (if applicable) Please circle: Mother Father Joint Other_____
School: _____ Grade: _____

Emergency Contact(s)
Who do we call in the event of an emergency?
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Responsible Party
Self Other:
Name: Last_____ First _____ Middle _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work Phone: _____
Where can we leave a message? _____
Email Address: _____
Date of Birth: _____
Mother occupation: _____
Father occupation: _____
Has Department of Social Services ever been involved with your family? _____
Is there a current court case or existing court documents related to custody of your child? _____
_____

Were you referred to our office? If yes, by whom? _____

Medical
Primary Care Physician: Name: _____ Number: _____
Psychiatrist: Name: _____ Number: _____

Previous Therapeutic Interventions (therapy, hospitalizations, etc): _____
_____
_____
Current Medications: _____
_____
_____
_____
Allergies: _____
Current Health Concerns: _____
_____
Do you currently use alcohol or drugs? If so, what substance do you use and how often? _____
_____
_____

Insurance Policy Holder Information
Policy Holder Name: _____
Relationship to Patient: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security Number: _____-_____-_____ Sex: _____
Employer: _____
Name of Insurance Carrier: _____
Subscriber ID#: _____ Group #: _____
Benefits Phone #: _____

*****Please be prepared to provide a copy of your insurance card and necessary identification and guardianship/custodial paperwork*****

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health assessment and/or treatment from Zola Counseling, PLLC. I understand that following the assessment and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of North Carolina Social Work State Board.
2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with play therapy, talk therapy, art therapy, or a combination of the above mentioned therapies. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations. Diagnosing is meant for treatment planning purposes, not for determining capability in any legal proceedings. Any labeling of behavior or events outside of treatment comes from client and/or client's guardian report and is not credible as an expert witness in legal proceedings.
3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments, coinsurance, meeting my deductible, and late/no-show/cancellation fees. Fees are available to me upon request. In addition, if a therapist within the practice is subpoenaed to court, please note that Zola Counseling, PLLC charges $300.00 per hour, which includes time spent in preparation for court appearance, time in discussing court related issues with attorneys or others involved in the court case, and the time spent from when he/she leaves the office until he returns to the office. This fee is NOT covered by insurance. Please be aware that our therapists are Not Forensic Evaluators and cannot perform Child Custody Evaluations.
4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at Zola Counseling, and I consent to its disclosure for use by Zola Counseling staff for the purpose of continuity of my child's care. Information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records. It is against policy for client or client caregivers to video tape or record audio of therapy sessions, parent consultation meetings, etc.
5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.
6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____

Signature of legal guardian for minor under age 18 **Date**

_____ _____

Signature of witness **Date**

Safe Harbor Agreement

The therapeutic goal is to permit children to have a place that they deem safe to be able to speak to a mental health provider about any apprehensions, concerns, or issues without fear that what they say will be used to interfere with, or create problems in their relationship with either parent.
In order to effectuate the stated goal, the parties acknowledge the importance of the therapist's office being a safe harbor- a place where children can be truthfully assured that what they say will not be disclosed to third parties without their consent.

Therefore, to create the safe harbor for children, the parties agree as follows:

1. No court/No depositions. Neither parent shall, nor will either parent permit his or her attorney to, subpoena the therapist or his/her notes to a trial, hearing, deposition, or arbitration.
2. No interrogations. Neither parent shall, nor will either parent permit his or her attorney to, demand answers from either the therapist or the child to questions about the content of therapy.
3. No disclosure. The therapist agrees that he/she shall not divulge to either parent, to either attorney, to the judge, or to any other third party, any matter relating to the content of the therapy with the children (except required disclosures under the Child Abuse Reporting Act, or other safety concerns) without the children's explicit consent.
4. No recording. It is against policy for client or client caregivers to video tape or record audio of therapy sessions, parent consultation meetings, etc.

Enforcement of Agreement:
Any party, or his/her attorney, who seeks to interrogate or subpoena the therapist shall be liable for all attorney fees and costs incurred to resist answering discovery requests or to quash a subpoena. Please note that Zola Counseling, PLLC charges $300.00 per hour, which includes time spent in preparation for court appearance, time in discussing court related issues with attorneys or others involved in the court case, and the time spent from when he/she leaves the office until he returns to the office. This fee is NOT covered by insurance. A retainer of $1200 is expected at time of request for participation in services. Please be aware that our therapists are Not Forensic Evaluators and cannot perform Child Custody Evaluations. Please be aware that your request for our therapists to participate in court may result in termination of services, as it is a breach of confidentiality of the client.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____

Signature of legal guardian for minor under age 18 **Date**

_____ _____

Signature of witness **Date**

Date: _____

Financial Agreement

Insurance

Services may be covered in full or in part by your health insurance or employee benefit plan. Please check your coverage carefully by calling your insurance provider prior to setting up counseling. It is your responsibility to know your co pay and deductible at your first session. By signing this form, clients agree to allow their therapist or billing agent to release information to their insurance provider to process claims. Clients also release insurance benefits to be paid to their therapist. Clients also agree to pay any portion not covered by their insurance carrier.

Payment

Please come prepared to pay your co-pay/coinsurance/service rate at time of service. We appreciate our clients and hope that you will be happy with your services here. We ask that you show your appreciation by paying in a timely manner. Any returning clients with a past due bill will be asked to settle this bill before resuming counseling. This is your therapeutic experience and paying for services helps you take responsibility for your change! Please refer to our cancellation policy, as additional fees may result for missed appointments, no show, late arrival, etc. We will hold a credit card on file. By signing this form, I acknowledge and understand that any outstanding debts that are not paid within 30 days of service date may be charged manually to my card. This can be avoided by attending all scheduled appointments, rescheduling following the cancellation policy, and paying at time of service. Zola is able to accept payment in the forms of cash, checks made out to Zola Counseling, PLLC, or credit card (visa, mastercard, discover, American express).

If you understand and agree with the above we ask that you sign this document as a statement of your understanding and agreement to comply with our financial and fee schedules. This document may be used along with your personal information to collect outstanding fees if not paid in a timely manner. If no attempt to pay for outstanding fees is made legal recourse may occur. Thank you for valuing our services by agreeing with these terms.

____ I wish to use my insurance benefits and have Zola Counseling submit claims on my behalf.
____ I will pay fee in full and will collect a superbill and submit claims for out of network coverage.
____ I do not have insurance coverage. I am a self-pay client and agree that I will not make attempts to submit to insurance at a later time.

Name on Card: _____
Credit Card Number: _____
Credit Card Type: _____
Expiration Date: _____
Security code on back: _____
Billing Address: _____

Client Name: _____
Legally Responsible Signature: _____
Witness Signature: _____

Date: _____

Cancellation/No Show/Late Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged $100; this will not be covered by your insurance company. We understand that delays can happen however we must try to keep the other patients on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment and it will also result in a $100 fee. You will be required to keep a credit card on file to be used for any late cancellation/No show/ late policy fees.

You may only have 2 "no shows" or late arrivals within a 6 month period. Should this occur, we will require that you meet with your current therapist to discuss the issues resulting in missed appointments to determine if termination from services is appropriate.

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients with balances over $100 must make payment arrangements prior to future appointments being made. By signing this form, I acknowledge and consent that my card may be charged as a result of any no shows, late arrivals, or late cancellations.

Name on Card: _____
Credit Card Number: _____
Credit Card Type: _____
Expiration Date: _____
Security code on back: _____
Billing Address: _____

Client Name: _____
Legally Responsible Signature: _____
Witness Signature: _____

Notice of Privacy Practices for Zola Counseling, PLLC

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Zola Counseling, PLLC. A copy of this signed, dated document shall be as effective as the original.

Client Name: _____
Guardian Name (if client is under 18): _____
Client/Guardian Signature: _____

Zola Counseling, PLLC may contact me at the following phone numbers regarding my appointments, treatment, and information about my health. Messages may be left unless otherwise noted.

Cell Phone: _____ NO messages: [ ]
Home Phone: _____ NO messages: [ ]
Work Phone: _____ NO messages: [ ]

Printed Name: _____
Signature: _____