Vision
COUNSELING & CONSULTING

Client Information

(Please Type or Print)

Date:_____ Patient's Full Name: _____

Address: _____

Street Apt. City/State Zip Code

Home Phone: _____ May we leave a message? ___Yes ___No

Work/Mobile/Other: _____ May we leave a message? ___Yes ___No

Email:_____

*Note: Email correspondence is not considered to be a confidential medium of communication.

Date of Birth: _____ Social Security #: _____ Marital Status: _____

Referred by (if any):_____ Relationship:_____

BILLING INFORMATION

EAP Company_____ Authorization #_____

Person Responsible for Bill (if different than patient name):_____

Address & Home Phone (if different than patient's):_____

Employer:_____ Job Title:_____

Insurance Company:_____ Member ID:_____

Emergency Contact

Name: _____ Phone #: _____

Relationship: _____

Presenting Issues (place a check mark next to the areas you wish to discuss):

- ❑ Relationship Issues
- ❑ Racial Issues
- ❑ Cultural Adjustment Issues
- ❑ Stress or Anxiety
- ❑ Depression
- ❑ Alcohol or Drug Use
- ❑ Development/Self-Esteem
- ❑ Health Concerns
- ❑ Suicidal Thoughts
- ❑ Career Concerns
- ❑ Loss Of Employment
- ❑ Religious/Spirituality
- ❑ Sexuality
- ❑ Death/Loss
- ❑ Family Problems
- ❑ Divorce/Separation
- ❑ Domestic Violence
- ❑ Trauma
- ❑ Sexual/Physical Abuse
- ❑ Legal Issues
- ❑ Parenting Issues
- ❑ Other: _____ _____

1. On a scale of 1 -10, with *1 being a minor disruption and 10 being an overwhelming disruption*, how would you rate your issue/issues?

2. Have you ever participated in counseling or therapy of any type? Yes No

3. Have you ever been hospitalized for a psychiatric problem? Yes No
If yes, please provide approximate date.

4. Have you experience any type of health problems over the last 2 years? Yes No
If yes, please explain.

5. Are you currently taking any medications? Yes No
If yes, please name the medications you are taking and the purpose of the medication.

6. Have you experienced any recent deaths (past 2 years)? Yes No

7. Are you feeling suicidal? No Yes, with thoughts only Yes, with plan

8. Are you wanting to hurt someone? No Yes, with thoughts only Yes, with plan

9. Do you have a support system currently?

10. Do you have a particular religious affiliation? Yes No

INSURANCE, PRIMARY CARE PHYSICIAN, AND REFERRING PSYCHIATRIST AUTHORIZATION

I understand that if therapy is being paid for using insurance, Dr. Littlejohn Hill will release any and all records pertaining to treatment to the insurance company, the primary care physician, or to your referring psychiatrist electronically, or by mail if such disclosure is necessary for claims processing, case management, coordination of treatment, or utilization review purposes. I hereby authorize payments for services rendered to be made either to me or on my behalf to Dr. Littlejohn Hill. I understand that I am responsible for any amount not covered by insurance.

Patient's Signature: _____ Date:_____
Insured's Signature (if different):_____ Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to ensure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. To obtain payment for treatment. I may use and disclose your PHI to bill and

collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:
1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations.
5. To avoid harm.
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the North Carolina Child Abuse and Neglect Reporting law and If North Carolina Elder/Dependent Adult Abuse Reporting law.
8. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
9. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
10. For Workers' Compensation purposes.
11. Appointment reminders and health related benefits or services.
12. If an arbitrator or arbitration panel compels disclosure.
13. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heathrelated benefits and services that may be of interest to you.
14. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.
15. If disclosure is otherwise specifically required by law.
C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
1. Disclosures to family, friends, or others. I may provide your PHI to a family

member, friend, or other individual who is your legal guardian and if you are under the age of 18.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right To Request Limits On Uses And Disclosures Of Your Phi Except For Those I Am Legally Required Or Permitted To Take.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method. I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures I Have Made.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI , you may request that I correct or add to the existing information, however, your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right To Get This Notice By Email And To Request A Paper Copy.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the

Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Lisa Littlejohn Hill, Ph.D. 704-785-5982

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

Vision
COUNSELING & CONSULTING

I acknowledge that I have received and read this HIPPA Notice of Policy Practices:

Print Name: _____ Date: _____

Signature: _____

Professional Disclosure Statement
Lisa Littlejohn, PhD, MA, LPC
Phone: 704-785-5982
visioncompanyllc@gmail.com

Qualifications

I hold a Doctorate in Counseling (2017) and a Master's in Counseling from the University of North Carolina at Charlotte (2011). I also have a BA in Sociology from Winthrop University (1998). I am a Licensed Professional Counselor in the state of North Carolina (#8923).

Counseling Background

The populations I serve include adults, adolescents, families and couples. I provide counseling services in both the individual and group settings. My main theoretical approach, as well as techniques used, stem from cognitive behavioral therapy, solution-focused brief therapy and logotherapy. I also operate from a Christian counseling modality. Essentially, I work with the client to improve thoughts as a means to change behaviors, cope with life circumstances and create meaning in one's life.

Length of Service and Session Fees

Sessions are last approximately 55 minutes. If insurance is used co-pays are taken at the time of visit. If you are not using your insurance, I charge $110 per session for individuals and $125 for couples. If attending a group, the fee for the entire group will be disclosed prior to the intake. I accept credit/debit cards and cash payments. Our work can only be effective with consistency and commitment. If you must cancel an appointment, please inform me at least 48 hours in advance. You are subject to payment for any missed appointments except in the case of personal emergency. Please be on time for your appointment. If you are late, your session will end at its scheduled time and you will be responsible for full payment.

Use of Diagnosis

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company.

Confidentiality

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Complaints

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx).

North Carolina Board of Licensed Professional Counselors
PO Box 77819
Greensboro, NC 27417
Phone: 336.217.6007
Fax: 336.217.9450
E-mail: LPCinfo@ncblpc.org

Acceptance of Terms

We agree to these terms and will abide by these guidelines.

_____
Client Name (PRINT)

_____ _____
Client Signature (or Parent/Guardian if under 18) Date

_____ _____
Counselor Signature Date