Toqui Kennedy, LPA
NC Parent Consultants
519 Keisler Dr. #202
Cary, NC 27518
(919) 271-2031

INTAKE PACKET

Client Name: _____
DOB: _____
Today's Date: _____
Primary Insurance Name: _____ Policy #:_____

Secondary Insurance: _____ Policy #: _____

SSN: _____

IDENTING INFORMATION
Home Address: _____ County: _____

Home Phone: _____ School/Grade: _____

Legal Guardian Name/Phone: _____

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

EMERGENCY CONTACT
First Contact: _____ Relationship to Client: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

Physician's Name/Phone: _____

Others in the Home (Names/Relationship to Client/Ages if appropriate): _____

_____

_____

Significant Others Involved with Client: _____

_____

MENTAL HEALTH/BEHAVIORAL INFORMATION
Reason for Seeking Services: _____

_____

Recent Treatment History (last 12 months): _____

_____

Pertinent Medical Issues: _____

_____

Client Medications: _____

Other Active Service Providers (last six months): _____

Court Involvement and/or Pending Charges: _____

Toqui Kennedy, LPA
NC Parent Consultants
519 Keisler Dr. #202
Cary, NC 27518
(919) 271-2031

CONSENTS/RIGHTS INFORMATION

I. Consent for Treatment

I hereby give my consent for **Toqui Kennedy** to provide mental health services to me/my child. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Client/Parent/Guardian: _____ Date: _____

II. Financial Release

I understand that **Toqui Kennedy** may use confidential information about me to bill and be paid for services. I hereby consent for **Toqui Kennedy** to release information to the billing agent, **Integrity Support Services** and its contracted clearinghouse, and/or to the funding source, and for the funding source to release information to **Toqui Kennedy** and **Integrity Support Services** for this purpose.

Client/Parent/Guardian: _____ Date: _____

III. Permission to Transport

I hereby grant permission for **Toqui Kennedy**, to provide transportation to my child, and agree to hold **Toqui Kennedy** harmless for any accident/injury that results from the provision of transportation.

Client/Parent/Guardian: _____ Date: _____

IV. Permission to Seek Emergency Medical Care

I hereby give consent for **Toqui Kennedy**, to seek and sign consent for emergency medical care in the event that I am unable to do so for myself. It is understood that **Toqui Kennedy** will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Client/Parent/Guardian: _____ Date: _____

Toqui Kennedy, LPA
NC Parent Consultants
519 Keisler Dr. #202
Cary, NC 27518
(919) 271-2031

V. Client Rights/Grievance Policies (See Handout)

I have received and had explained to me the Client Rights handout. **Toqui Kennedy** gave me this handout and verbally explained my rights as a client.

Client/Parent/Guardian: _____ Date: _____

VI. Privacy Rights (See Handout)

I have received and had explained to me the Privacy Rights handout. **Toqui Kennedy** gave me this handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client/Parent/Guardian: _____ Date: _____

I understand that one of my rights is to be able to choose how I am contacted.
I ***do/do not*** *(please circle one)* give permission for **Toqui Kennedy** to contact me at work.
Furthermore, I ***do/do not*** *(please circle one)* give permission for **Toqui Kennedy** to leave voice messages for me at ***home/work/both/neither*** *(please circle one).*

Client/Parent/Guardian: _____ Date: _____

I, **Toqui Kennedy**, have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; and the Service Description to the Client/Parent/Guardian of the client to be served.

Signature: _____ Date: _____

Clinical Services and Counseling Fee Agreement

1. **Initial Intake Fee** -- The initial intake fee is $150.00. For clients that prefer not to use their mental health insurance, at least half of the initial intake fee is due on the first visit, with any remaining paid toward a balance during following visits.
2. **Counseling Sessions** -- Clients must pay for services at the beginning of each session. If a client is insured for mental health services and has a co-pay, that co-pay is due at the beginning of each session. A sliding scale based on the ability to pay for services is also offered for those clients falling into the low to moderate-income levels and for those clients that prefer to not use their mental health insurance. If the client chooses not to provide income verification, the client will be billed at $120.00 per session.
3. **Sliding Scale** -- The sliding scale will be based on household income to be determined by either last year's tax return or three consecutive payroll stubs. The amount of the sliding scale is calculated as follows: for every $1000.00 of annual income the session rate increases by $2.00 with a cap of $120.00 and a minimum of $50.00. $4000.00 is deducted from the total annual income for every claimed dependent. For example, a client with an income of $50,000.00 with three dependents would have a sliding scale rate of $76.00 ($50,000 - $12,000 worth of dependents = $38,000 annual income).
4. **Cancellations and/or Missed Appointments** -- Clients must cancel sessions **24 hours in advance** or they will be charged a flat fee of $50.00 for the missed session. Clients that fail to appear for their scheduled session **without any notification** will be charged a flat fee of $120.00 for the missed session. Clients who cancel and/or miss **3 consecutive sessions**, upon written notification, will be placed on the waiting list and/or will be given an outside referral. Voicemail is always available should you find the need to cancel.
5. **Court Evaluations/Documentation** -- Fee for a four-hour document preparation is $200.00. The evaluation fee must be paid prior to the release of the Court Evaluation Report. The fee for a simple one page counseling verification letter to an attorney or court system official is $10.00.
6. **Court Appearances** -- A flat fee of $400.00 will be charged each day for clinical court appearances on behalf of the client. A written and signed letter must be obtained from the client and/or its representative at least one week prior to the court date.
7. **Transfer or Release of Records to Outside Agencies or Persons** -- A written, dated, and signed consent form must be obtained from the client or legal guardian prior to the release of the client's file. A service fee of $10.00 will be charged for records exceeding 5 pages.
8. **Returned Checks** -- Clients are responsible for any bank fees incurred due to returned checks. A bank service fee of $25.00 per check will be charged to the client.

The financial information I provide is true and complete to the best of my knowledge. I will inform the therapist of any changes to my household that might impact my fee. I agree to pay all charges incurred by me and/or my family members.

_____ _____

Client Name *Date*

_____ _____

Parent or Legal Guardian (if client is under 18 years of age) *Date*