Leslie M. Hardy, MSW, LCSW, LCAS
Counseling, Coaching & Consulting Services
809 Spring Forest Road, Suite 1000
Raleigh, NC 27609
(919) 919-434-3555

Client:_____

D.O.B:_____/_____/_____

Thank you for reaching out to inquire about our services. Please review and complete this Intake Packet and review the Rights & Responsibilities Handbook (RRH).

- The RRH is for you to keep for your reference.
- Please print, complete and sign the Intake Packet and Service Fees forms in **Black** Ink only.
- Please complete the Insurance Verification information (if applicable) and **email** back ASAP and at least 48 hours *prior to* the day of your appointment to ensure adequate time for your insurance benefits to be verified by our office.
- **Please Note:** You are responsible for paying the full cost of all services rendered *prior to the verification of your insurance.*
- *A*ll services must be paid at the **beginning** of or prior to each appointment.
- Our office does not accept checks for the first, initial appointment. If you wish to use a Credit/Debit card, please see instructions within Consent form attached. Otherwise, please bring cash.

Please bring the following items with you to your appointment: Completed Intake Packet, Signed Service Fees form, Credit/Debit card to be put on file and Cash (co)payment, along with a copy of your Insurance card (if applicable).

Please bring the exact change as cash is not kept on hand; otherwise, a credit balance will be applied to your account.

Please provide a 24 hour notice if you are unable to keep your appointment. Thank you for your cooperation and I look forward to meeting and working with you!

Please feel free to contact the office should you have any questions prior to your appointment.

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Counseling, Coaching & Consulting Services

809 Spring Forest Road
Suite 1000-Synergy Center
Raleigh, NC 27609
Telephone: 919-434-3555
Email: ContactUs@LeslieMHardy.com
Website: www.LeslieMHardy.com

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NEW CLIENT INFORMATION

1. CLIENT INFORMATION: Please Print Legibly **Today's Date**: _____/_____/_____

Name:_____
(First) (Middle/Maiden) (Last)

Home Address: _____
Street City State Zip

Home Phone: (_____) _____ May we leave a message? Yes ☐ No ☐

Work Phone: (_____) _____ May we leave a message? Yes ☐ No ☐

Cellular Phone: (_____) _____ May we leave a message? Yes ☐ No ☐

Personal Email: _____ May we send a message? Yes ☐ No ☐

* NOTE: Email is not considered to be a confidential means of communication. Email will not be used by this office to correspond about any clinical / therapeutic matters. An appointment must be scheduled accordingly.

DOB:_____/_____/_____ Age:_____ Gender: Male ☐ Female ☐

Employer: _____ Job Title: _____

Education: Graduated High School? _____ Graduated College? _____ Major: _____

2. FAMILY: Relationship Status:_____ Name, Age, Relationship of persons living in your household:

_____

_____

3. EMERGENCY CONTACT PERSON:

Name: _____ Employer: _____

Home#_____ Work#_____ Cell#_____

Address:_____

4. PRIMARY CARE: From whom do you (client) receive your primary medical care?

Facility / Doctor's Name: _____ Phone#: (_____) _____

Address: _____ City: _____Zip:_____

Current Medications:_____

5. PRIOR SERVICES: Have you (client) received therapy services before? Yes ☐ No ☐

Therapist's Name: _____Dates of Treatment: _____

Address: _____

Current Psychiatric Medications:_____

Prescribing Physician: _____

6. REFERRAL SOURCE: Please indicate how you heard about Leslie Hardy, LCSW Counseling & Consulting:

___ Professional Referral (Dr./Attorney/Etc) ___ Friend/Colleague ___ Family Member
___ Insurance Provider ___ Brochure/Flyer ___ Website / Internet ___ Other

Name / Address / Phone of who referred you:_____

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May we thank this person? Yes ☐ No ☐

1. What are the main reasons for seeking psychological services at this time? _____
   _____
   _____
2. What efforts have you made to deal with these concerns? _____
   _____
   _____
3. Are you currently having suicidal thoughts? Yes ☐ No ☐
4. How often do you drink alcoholic beverages? ☐ Daily ☐ Weekly ☐ Monthly ☐ None
5. How often do you use non-prescription drugs? ☐ Daily ☐ Weekly ☐ Monthly ☐ None
   Name of drugs and how often used:_____
6. When was the last time you had a physical? _____
7. How would you rate your current physical health? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good
8. How many hours of sleep do you average nightly? _____
9. How would you rate your sleeping habits? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good
10. How many times per week do you generally exercise? _____
11. Do you consider yourself to be religious or spiritual? Yes ☐ No ☐
    If so, please describe your faith / beliefs: _____
12. What would you like to accomplish as a result of therapy?_____
    _____
    _____

Please Check Any of the Following Symptoms That the Client Has Been Experiencing Recently:

☐ Academic concerns	☐ Abuse by others	☐ Abuse of others	☐ Aggression
☐ Anxiety	☐ Anger	☐ Irritability	☐ Child concerns
☐ Depression	☐ Mood Swings	☐ Phobia/Fears	☐ Parenting concerns
☐ Sleep Difficulties	☐ Eating concerns	☐ Lack of Energy	☐ Job concerns
☐ Physical Pain	☐ Crying Spells	☐ Wanting to be alone more	☐ Sexual concerns
☐ Chronic Pain	☐ Judgment errors	☐ Family member concern	☐ Financial concerns
☐ Nightmares	☐ Drug Use	☐ Relationship Problems	☐ Career change
☐ Disorientation	☐ Alcohol Use	☐ Sibling concerns	☐ Physical concerns
☐ Nervousness	☐ Hopelessness	☐ Health concerns	☐ Poor self concept
☐ Low self-esteem	☐ Impulsivity	☐ Memory Impairment	☐ Ideas of harming self
☐ Fatigue	☐ Distractibility	☐ Lack of real friends	☐ Difficulty Concentrating
☐ Grief/Loss	☐ Recurring thoughts	☐ Ideas of harming Others	☐ Pregnancy

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NEW CLIENT INTAKE FORM

In order for us to have a better understanding of your problems, please answer the following questions. Any information you provide to us on this form will not be released to any outside person or agency without your permission. Please note, each item refers to your *entire life history*, not just your current situation.

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? **YES** **NO**
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? **YES** **NO**
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? **YES** **NO**
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? **YES** **NO**
5. Have you ever heard voices no one else could hear or see objects or things, which others could not see? **YES** **NO**
6. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? **YES** **NO**
7. Have you ever made an attempt to kill your self? **YES** **NO**
8. Have you ever had nightmare or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? **YES** **NO**
9. Have you ever experienced any strong fear? For example fear of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? **YES** **NO**
10. Have you ever given in to an aggressive urge or impulse on more than one occasion that resulted in serious harm to others or led to the destruction of property? **YES** **NO**
11. Have you ever felt that people had something against you without them necessarily saying so, or to influence your thoughts or behavior? **YES** **NO**
12. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities or your choice of sexual partner? **YES** **NO**
13. Have you ever had a period of time when you were so full of energy and your ideas came vary rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? **YES** **NO**
14. Have you ever had spells or attack when you suddenly felt anxious, frightened, uneasy to the extent you began sweating, your heart begin to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? **YES** **NO**
15. Have you ever had a persistent lasting thought or impulse to do something over and over that caused you distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things you had done, washing and rewashing your hands, praying, or marinating a very rigid schedule of daily activities from which you could not deviate. **YES** **NO**
16. Have you ever lost considerable sums of money through gambling problems at work, school, with family and friends as a result of your gambling? **YES** **NO**
17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? **YES** **NO**

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Client:_____

D.O.B:_____/_____/_____

CONSENT for SERVICES

CONFIDENTIALITY: Therapy sessions are confidential and neither verbal nor written information about a client can be released without the written consent of the client or the client's legal guardian, with a few exceptions.

SERVICES: The foundation of our work is based in "Cognitive Behavioral" approaches to create change. We offer a variety of services, including individual, couples, and family therapy/counseling services as well as groups, workshops, seminars, training opportunities. We provide treatment for mental health issues, including mood disorders, job/career/school issues, and relationship or parental discord. Although we can't change the past, our goal is to help individuals gain clarity of thoughts and feelings, develop positive goals, and create and implement a plan of action to achieve those goals so they may realize more fulfilled lives. Therapy/counseling appointments are **50 minute sessions** unless otherwise indicated. Each appointment will begin at the **scheduled time** (whether client is present or not) with transition to end the session 45 minutes after its scheduled start time. There will be a $25 fee assessed, per 15 minute increment, for any time beyond the 50 minute session.

CANCELLATION: If a scheduled appointment must be cancelled, we require **24 hour** notice. Please schedule carefully. If client fail to cancel a scheduled appointment within 24 hours and/or miss the appointment, we cannot use that time for another client and a **$75 cancellation fee**, will be charged, due immediately, which is not reimbursable by insurance.

FEES AND PAYMENT: Many services provided are covered under health insurance plans. Mental health benefits vary widely from plan to plan. Clients are strongly encouraged to review their health insurance plan carefully to be aware of mental health coverage. It is the client's responsibility to know his/her insurance benefits, whether using in-network or out-of-network benefits, and any limitations of the coverage. Leslie Hardy, LCSW, LCAS participates as an in-network provider with Blue Cross Blue Shield and out-of-network with most others.

A valid, current Credit / Debit card is required *to be on file at all times to process any and all fees for service, including late cancellation fee(s). Client authorizes Leslie Hardy to process any and all fees using the credit card as needed.*

Payment (co-payment): Payments may be paid by Cash, Check or Credit/Debit Cards. All payments must be submitted and paid prior to the beginning of the session. Clients are responsible for the submission of payments to be processed. To submit an online payment:

1. Go to our website (www.LeslieMHardy.com),
2. Click on the "L-Store" tab and Click "Pay Now". All credit / debit card payments will incur a **processing fee**.
3. Any payments not made by midnight of the appointment day will be assessed a **late fee**, NO EXCEPTIONS.

NOTE: Paypal may not process Flex Spending Cards. Therapist will be glad to give client a receipt for payments to use toward any possible reimbursements from Flex Spending accounts.

Clients are responsible for ALL charges incurred during and related to the course of treatment, whether the insurance company pays or not. Leslie Hardy reserves the right to cease acceptance of check / credit / debit card payments. Services may be terminated for lack of timely payment of services. We apologize in advance for any inconvenience.

INFORMED CONSENT: "I have read the above information, understand it, and I agree to the above conditions."

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:**_____
(If client is under 18 years of age)

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D.O.B:_____/_____/_____

SERVICE FEES &
AUTHORIZATION CONSENT

Service	**Fees**	**Code**
Initial Evaluation Appointment	$150.	90791
Individual Therapy	110.	90837
Family Therapy	120.	90847
Marriage/Relationship Counseling	120.	n/a
Out of Office Appointments / Consultation related to:		
School / Other + Travel & related fees	125/hr	n/a
*Court / Legal proceeding + Travel & related fees	150/hr	n/a
Telephone Consultation (w/Client/Guardian/MH Prof)		
Brief up to10 minutes	No Charge	n/a
Lengthy 11-45 minutes	75.	n/a
Extended 46-75	110/hr	n/a
In Office Consultation	110/hr	n/a
All services exceeding time limits (each 15 min increment)	25.	n/a
Documentation Preparation (i.e. treatment summary, court, school, etc.)	75/hr	n/a
Missed Appointment (This is Not covered by Insurance)	75.	n/a
Late Cancellation Appointment (This is Not covered by Insurance)	75.	n/a
Information Transfer / Copying (up to 20 pages)	25.	n/a
Return Check / NSF Fees	40.	n/a

All services are based on one clinical hour (45-50 minute), during normal, weekday office hours.
All services outside of normal, weekday office hours will incur an additional $30 extended hours fee.
All Services coded as "n/a" are NOT reimbursable by insurance companies (or may require prior authorization) and ***must be paid in advance.*** Thank you.

NOTE: * At any time during the course of treatment the client/guardian becomes involved in court / legal proceedings and/or there is a *high probability* there may be a need for the professional services of Leslie M. Hardy, LCSW, LCAS by either party, a $1000 retainer will be required immediately, in addition to any other related fees as noted above.

I understand a valid, current Credit / Debit card is required to be on file at all times to process any and all fees for service, including late cancellation fee(s). I authorize Leslie M. Hardy, LCSW, LCAS to process my credit/debit card accordingly.

Your signature indicates you have read, understood and agreed to fees and conditions stated above.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:**_____
(If client is under 18 years of age)

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Client:_____

D.O.B:_____/_____/_____

INSURANCE VERIFICATION

Pease fill out this form completely will all requested information, writing "n/a" (not applicable) as needed. Any missing information may result in a delay in verification, in which you will be responsible for the FULL cost of any services rendered prior to verification of benefits. We require a minimum of 2 business days *prior to the date of your appointment* to verify your insurance benefits.

Client Name: _____ DOB: _____/_____/_____ M / F

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Subscriber ID#:_____ Group ID#: _____ Relation to Client: _____

Subscriber Address:_____

Insurance Co. / Plan:_____/_____
Ex. BCBS / State Health Plan

Effective Date: _____/_____/_____ Benefit Period (Calendar yr; June-July, etc.) _____

Deductible? Yes ☐ No ☐ Deductible Amount $_____ / Met $_____ / Co-Insur_____

Co-Pay Amount:$_____._____ MH Elig &Verification #:(_____)_____

Are your mental health benefits covered by a different company? _____ If yes,

What is the name of the company that covers your mental health benefits_____

Number of mental health out-patient visits you are allowed per year? _____

Do you need prior authorization before treatment? Yes __ No __ If yes, what is the authorization # _____

Mental Health /. Behavioral Health Services are professional, "medically necessary" services, hence why they may be insurance billable. Because of its nature, designated time must be allocated for the provision of these services to accommodate only one client/patient at a time per any scheduled time slot. As a result, it is imperative to the operation of services and the continuity of treatment for clients to keep all scheduled appointments. Failure to comply with treatment services will result in a termination of services.

NOTES: _____
_____
_____
_____
_____
_____
_____

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FINANCIAL AGREEMENT
SIGNATURE OF FILE

(Please initial each line and sign at the bottom of the page)

_____ I understand that I am responsible for my bill.

_____ I authorize use of this form on all my insurance submissions, should I choose to use my insurance plan.

_____ I authorize the release of information to my insurance company relevant to the processing of insurance claims for myself or my dependent should I choose to use my insurance plan. .

_____ I authorized Leslie Hardy, LCSW, LCAS to act as my agent in helping me obtain payment from my insurance companies, should I choose to use my insurance plan.

_____ I authorize direct payment to Leslie Hardy, LCSW, LCAS Counseling and Consulting.

_____ I permit a copy of this authorization to be used in place of the original.

The space below is intentionally left blank

Client Signature: _____ **Date:** _____

- Relationship if not Client / Patient_____
- The signature of a parent or legal guardian is required if the patient is under 18 years of age or legally Incompetent.

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Client:_____

D.O.B:_____/_____/_____

FINANCIAL AGREEMENT 2

(Please initial each line and sign at the bottom of the page)

_____ I understand a **valid, current Credit** / **Debit card** is required to be on file at all times to process any and all fees for services, including late cancellation / no show fee(s). I authorize Leslie M. Hardy, LCSW, and LCAS to process my credit/debit card accordingly.
.

Credit / Debit Card Information:

Name as it appears on your card: _____

Card Number: _____

Card Type: (Visa, Master Card) _____

Expiration date: _____ / _____ CVC # (3-5 digit number on back of card): _____

Billing Address for Card: _____

_____

Mobile phone number: (_____)_____

The space below is intentionally left blank

Client Signature: _____ **Date:** _____

- Relationship if not Client / Patient_____
- The signature of a parent or legal guardian is required if the patient is under 18 years of age or legally incompetent.