Loaves and Fishes Counseling of Beaufort

1730 Live Oak Street Mailing Address: PO Box 2535

Beaufort, NC 28516 Beaufort, NC 2851

252.838.9035 Fax: 252.838.1156

[www.loavesandfishesnc.org](http://www.loavesandfishesnc.org)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status: \_\_\_\_\_\_\_\_\_\_\_\_\_Sexual Identity:\_\_\_\_\_\_\_\_\_\_Gender: \_\_\_\_\_\_\_\_Race:\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Benefactor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Criminal History: (Past/Present) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Upcoming Court Dates and County:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attorney Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Probation: Yes/No Officer’s Name and County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you court ordered to treatment? Yes/No County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Treatment Ordered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Charge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you completed detox: Yes/No Name of Detox: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Completed: \_\_\_\_\_\_\_\_\_Point of Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly explain why you are seeking treatment at Loaves and Fishes Counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Patient History***

Please list all current and past mental health diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any food or drug allergies: Yes/No Please list below if you answered “yes”.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical? \_\_\_\_\_\_\_\_\_\_\_\_Current Healthcare Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted to harm yourself or someone else? Yes/No If you answered “yes”, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is a family history of mental illness, please list relationship and condition below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been Involuntarily Committed? Yes/No If you answered “yes”, please explain and give name and address of where you were treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current health conditions/diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any physical limitations: Yes/No If you answered “yes”, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been tested for HIV, Hep-C, or TB? Yes/No Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last use: \_\_\_\_\_\_\_\_\_\_\_ What was your drug of choice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all substances used/abused: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been discharged from another treatment facility and for what reason(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Financial Policies and Agreement***

|  |  |  |
| --- | --- | --- |
| **Fee** | **Amount** | **Purpose** |
| Intake Fee | $750.00 | First month dues, administrative fee, early discharge fee, assessment fee |
| Monthly Fee | $500.00 | Treatment and Housing (medication not included)Payments due on date of entry each consecutive month. |
| Gym Membership | $20.00 | Due the 1st of each month(Not included in monthly fees) |
| Petty Cash | Varies | Residents will receive no more than $10.00 per day. |

Financially Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: (No PO Box) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sec. Code\_\_\_\_\_\_\_\_Exp. Date\_\_\_\_\_\_\_\_\_\_

Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I understand and agree that there will be no refunds given under any circumstance. Fees are also not prorated.***

***Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

*I authorize Loaves and Fishes to charge my credit card upon the aforementioned date(s) for the specified amount until this authorization is revoked or changed by the payer in writing. I also agree to have the card listed above charged for petty cash, medications, or other incidentals. I understand that* ***ALL FEES ARE NOT REFUNDABLE UNDER ANY CIRCUMSTANCE.***

Authorized Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Financial Policies and Agreement (Cont.)***

Incidentals, medication, food, and other items not listed above are not included in the monthly residential fee. If a patient would like to have a card on file for petty cash, he or she will need to make the proper arrangements with the benefactor. The patient will only receive a maximum of $10.00 per day. If the patient has a debit/credit card, it will be held in the financial office as well. If you wish to leave card information on file to be used for the items beyond the monthly fee, please fill out the section below.

Financially Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: (No PO Box) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sec. Code\_\_\_\_\_\_\_\_Exp. Date\_\_\_\_\_\_\_\_\_\_

Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Would you like us to call prior to using your card? Yes/No

*By signing below, I authorize Loaves and Fishes Counseling to utilize this authorization for incidental charges, petty cash, or any other charge needed for the good of the patient. I understand and agree that my card will not only be charged, but that there are no refunds of fees of charges under any circumstances. I also understand that my information may be given to third parties for the continued care of the patient.*

*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***General Informed Consent***

*This general informed consent applies to all licensed, provisionally licensed, registered and intern status clinicians with Loaves and Fishes Counseling. This consent also serves as a general consent for pastors, Peer Support Specialists, support staff, interns, and other individuals that may be involved in the treatment process. Treatment will be provided in individual sessions and group sessions.*

**Counseling Background:**

Each individual provides services to a diverse population to include: men, women, couples, and families. Theoretical orientations are evidence based when applicable. Each clinician, when required, is under clinical supervision by a licensed supervisor with the NCSAPPB.

**Services Offered/Staff**

We provide inpatient, outpatient, individual, family and group counseling. At Loaves and Fishes Counseling, we have adopted a team approach to treatment and counseling. Our treatment team is made up of paraprofessionals, volunteers, provisionally licensed counselors, licensed counselors, interns, peer support specialists, and pastors. Due to the nature of many of our groups, this team may change without notice. All members of our treatment team have signed confidentiality agreements which both educate them and bind them to hold all information in the strictest confidence per HIPAA Privacy Rule, *45 C.F.R.* § 164.508(c)(2)). Each member of our team has also completed HIPAA training provided by NCDHHS and must complete continuing education credits each year to remain in compliance with Loaves and Fishes Counseling and the appropriate boards. It is our desire to keep each patient safe and make decisions that are both beneficial for the individual and the other patients. Group therapy and individual therapy is provided for each patient. The guidelines and limitations of confidentiality apply to group counseling as well. Although some patients will require weekly individual treatment, this is not the case for all patients. A person-centered treatment plan will be put in place for all patients.

**Session Fees and Length of Service**

Individual counseling sessions are 50 minutes in length. Group sessions are 1-3 hours depending upon type of treatment being provided. Clinical Assessments can vary in length from 1 to 1.5 hours. Inpatient fees are listed in the financial contract. Outpatient fees are listed on our fee list which is provided to all outpatient clients. Fees are to be paid prior to the beginning of each session and/or intake. Outstanding fees may be collected by a third-party collection agency if an account is 30 or more days past due.

**Confidentiality**

All 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 that you are a danger to yourself or someone else, (c) I am ordered by a court to disclose information, and (d) if you disclose abuse to a child, elder, or handicapped individual.

**Referral/Termination**

In the event that the counseling relationship must terminate or if the counselor becomes incapacitated, all clients will be referred to another provider within the agency. Prior to terminating the counseling relationship, the client will be notified of said termination. In the event that a referral is necessary, the counselor will take the proper steps to help the client through this transitional period.

**The Counseling Relationship**

The relationship between client and counselor will develop over time. Although this relationship may become a powerful tool in the life of the client, the client must understand that this relationship is strictly professional. The counselor also reserves the right to record sessions via audio or video. By signing below you understand that you may be recorded for safety purposes or training purposes.

**Complaints**

Although clients are encouraged to discuss any concerns with the counselor, you may file a complaint against the provider with the organization(s) below should you feel that the counselor is in violation of any of these codes of ethics.

North Carolina Substance Abuse Professional Practice Board

PO Box 10126

Raleigh, NC 27605

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

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

Clinician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

***Clinical Supervisor Informed Consent***

***Professional Disclosure Statement/Informed Consent***

Jarod Cruthis, MA, Ed.D, LCAS, CSI, QP

Clinical Program Director/Clinical Supervisor

Office: 252-622-0628

Email: director@loavesandfishesnc.org

**Note to Residential Patients:**

*As the Clinical Program Director for Loaves and Fishes Counseling, it is necessary for you to be provided with a copy of my personal informed consent. Even though I may not be engaged in direct therapeutic work with you, I do supervise other clinicians, the staff of Loaves and Fishes, as well as review and consult on all cases. You may attend a group which I facilitate, undergo an assessment or other clinical testing, be assigned to me as a client, or I may be asked to sit in and observe a session with you and your therapist. Therefore, it is ethically necessary for you to be informed of my position, qualifications, and standards, as well as those of your individual therapist and our entire care team. Your treatment/case will be regularly discussed with our treatment team; therefore, if the treatment team deems it necessary to consult with you on a matter, you will be asked to attend a Team Meeting to discuss the matter and review your case. This may include but is not limited to case management, therapeutic interventions, therapy notes, medical issues, education, vocational, and disciplinary issues. It should also be understood that I provide both clinical and Biblical counseling. I strive to respect diversity and will provide clinical counseling in the individual setting only, at the request of the patient. It must be understood by the patient, that my Advanced Informed Consent is a statement of my Christian worldview. If at any time I feel that my personal religious views would interfere with providing you with the best ethical care possible, I will inform you as to my position and refer you to another appropriate provider.*

**Qualifications:**

The counselor’s professional and educational qualifications are as follows:

* Relevant Degree:
	+ Master of Arts in Professional Counseling from Liberty University. Degree awarded May 2014.
	+ Other (Bachelor of Arts in Biblical Studies/Master of Arts in Christian Education/Doctorate of Christian Education)
* Certificates:
	+ Treatment and Theory of Substance Abuse (AACC)
	+ Professional Life Coaching 101 and 102 (AACC)
	+ Stress and Trauma Care with Military Application (AACC)
	+ Certified Cognitive Behavioral Therapist (2019)
* Credentials:
	+ Licensed Clinical Addictions Specialist (NCSAPPB)
	+ Clinical Supervisor Intern (NCSAPPB)
* Counseling Experience
	+ Cruthis has been providing counseling services (substance abuse, mental health, and/or pastoral counseling) for the past 18 years. Dr. Cruthis practices non fee-based pastoral/biblical counseling and fee-based clinical substance abuse counseling, which includes working with dually diagnosed patients.

**Counseling Background:**

Dr.Cruthis provides services to a diverse population to include: men, women, couples, and families. His theoretical orientation is eclectic and includes but is not limited to: Cognitive Behavioral, Psychodynamic, Motivational Interviewing and Gestalt approaches to therapy.

**Session Fees and Length of Service**

Dr. Cruthis’ outpatient fees do not reflect those set forth by Loaves and Fishes Counseling. You are provided a list of fees for inpatient services through which his professional services are included. Individual counseling sessions are 50 minutes in length. Group sessions are 1-2 hours depending upon the type of treatment being provided. Clinical Assessments can vary in length from 1 to 1.5 hours. Fees are to be paid prior to the beginning of each session. Fees can be paid by cash, money order, or credit card. Outstanding fees may be collected by a third-party collection agency if an account is 30 or more days past due. Individual outpatient fees are as follows:

* Comprehensive Clinical Assessment: $175.00
* Individual Counseling Session: $100.00 (per 50 minute session)
* Marriage and Family (Couples Counseling): $150.00 (per 50 minute session)
* Group Counseling: $10.00 per person per group.
* Clinical Supervision: $50.00-$75.00 per hour.
* No call/No show Fee: $50.00
	+ Two missed appointments without 24-hour notice, may result in termination of services. At this time, you will be referred to another counselor and given an aftercare plan so to continue your counseling with another provider/agency.
* Dr. Cruthis’ inpatient services are covered under the monthly fee and are provided at no additional charge.

**Use of Diagnosis**

If a qualifying diagnosis is appropriate for your case, the therapist will inform you of the diagnosis before the final diagnosis is documented. Any diagnosis made will become part of your permanent insurance records.

**Confidentiality**

All of our communication becomes part of the clinical record, which is accessible to you upon request. All information will be kept confidential. Anything you say as part of the counseling relationship is confidential with the following exceptions: (a) you direct the therapist/agency to disclose in writing your records to someone else, (b) it is determined that you are a danger to yourself or someone else, (c) a court orders the therapist to disclose information, and (d) if you disclose abuse to a child, the elderly, or handicapped individual.

**Referral/Termination**

If the counseling relationship must terminate or if the counselor becomes incapacitated, all clients will be referred to another provider within the agency. Prior to terminating the counseling relationship, the client will be notified of said termination. If a referral is necessary, the counselor will take the proper steps to help the client through this transitional period.

**Self-Harm Agreement**

If you feel as if you may become a threat to yourself, or you are having thoughts of harming yourself, you agree to contract with your counselor and utilize the following guidelines:

* Call 911 and seek immediate help.
* Call your counselor during normal business hours and report. (252-622-0628)
* Call the National Suicide Lifeline and follow their instructions. (1-800-273-8255)

The purpose of this agreement/contract is to protect you and those around you. There is never a situation that you may face that should be handled by inflicting harm to yourself. There is always hope and help available. This contract between you and your counselor is made valid and binding by the signing of this consent form. There may be a time during treatment that an additional contract may be presented to you as well.

**Advanced Informed Consent**

Although I provide clinical substance abuse and mental health counseling (dual-diagnosis), my clients have the right to be informed of my worldview. As a Christian, my worldview was developed and continues to develop based upon Biblical Truth. In the event that I feel that my Christian worldview may interfere with treatment, I agree to inform you of that conflict and refer you to a clinician that can provide the best care possible. I provide clinical services, pastoral counseling, and integrative therapy.

While my worldview is Christian, I follow Loaves and Fishes non-discriminatory policy; therefore, if you choose clinical counseling only, then I am happy to provide those services on an individual basis. This, however, does not apply to the group treatment curriculum or treatment program.

**Complaints**

Although clients are encouraged to discuss any concerns with the counselor, you may file a complaint against the provider with the organization(s) below should you feel that the counselor is in violation of any of these codes of ethics. Cruthis abides by the ACA and AACC Codes of Ethics.

North Carolina Substance Abuse Professional Practice Board

PO Box 10126

Raleigh, NC 27605

919-832-0975

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

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

Clinician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

***CASE MANAGEMENT CONSENT FOR RELEASE OF INFORMATION***

**Loaves and Fishes Counseling Ministries**

1730 Live Oak Street ▪ Beaufort, NC 28516

 (252) 838-9035 fax: (252) 838-1156

NAME: DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the release and/or exchange of specified information regarding my medical and psychological condition, history, and treatment *between* **Loaves and Fishes Counseling Ministries** and the person/provider(s) listed below per Privacy Rule, *45 C.F.R.* § 164.508(c)(2)):

* ***Carteret Health Care\_\_\_\_\_***
* ***Medical Park Pharmacy East\_\_\_\_\_***
* ***Open Water Medical\_\_\_\_\_***
* ***Carteret County Department of Social Services\_\_\_\_\_***
* ***North Carolina Courts and Justice System\_\_\_\_\_***
* ***Vocational Rehabilitation\_\_\_\_\_***
* ***Emergency Contacts (As listed on Residential Application)\_\_\_\_\_***
* ***Financial Responsible Party (As listed on Residential Application)\_\_\_\_\_***

This information shall include only that of the nature and to the extent which is specified below:

INFORMATION TO BE RELEASED: PURPOSE FOR RELEASE:

[ ] All Admission and Discharge [ ] For Diagnostic Purposes

[ ] Summary of Prior Treatment [ ] For Continuity of Care

[ ] Verbal/Written Updates as Needed [ ] For Coordination of Care

[ ] Current Medications [ ] Date Range \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] History of Psychotropic Drugs [ ] All Dates of Treatment

[ ] Medical/ Psychiatric/ Psychotherapy Progress Notes

[ ] Laboratory and Radiology Reports

[ ]

I understand that information to be released, may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and/or AIDS or physical conditions. I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be disclosed without my further written consent unless provided for by state and federal law. I understand I may revoke this authorization at any time, except to the extent that action has already been taken. Unless otherwise revoked, this consent will expire one year from the date of consent.

 OR

Patient Signature Parent / Guardian Signature

Therapist Signature Date of Consent

**I hereby revoke this authorization effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR RELEASE OF INFORMATION**

**Loaves and Fishes Counseling Ministries**

1730 Live Oak Street

Beaufort, NC 28516

 (252) 838-9035 fax: (252) 838-1156

NAME: DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 OR

Patient Signature Parent / Guardian Signature

Therapist Signature Date of Consent

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

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**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR RELEASE OF INFORMATION**

**Loaves and Fishes Counseling Ministries**

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 (252) 838-9035 fax: (252) 838-1156

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I hereby revoke this authorization effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Consent to Treat***

By signing and initialing below, I attest that I have been given copies of and/or allowed to review each document listed. I also attest that I understand and agree to all the information presented to me upon intake. I hereby give my consent to be treated according to the guidelines and treatment protocol of Loaves and Fishes Counseling.

\_\_\_\_\_\_ Liability Waiver \_\_\_\_\_\_ Emergency Plan

\_\_\_\_\_\_ Residential Rules/Policies \_\_\_\_\_\_ Disciplinary Policy

\_\_\_\_\_\_ Electronic Records Disclosure \_\_\_\_\_\_ No Refund Policy

\_\_\_\_\_\_ Non-Discriminatory Policy \_\_\_\_\_\_ Statement of Faith

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intake Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_