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: \_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_

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. |
| 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.

**Confidentiality**

All communication becomes part of the clinical record, which is accessible to you upon request. We will keep confidential anything clients say as part of our counseling relationship with the following exceptions: (a) a patient directs us in writing to disclose information to someone else, (b) it is determined that a patient is a danger to themselves or others, (c) our agency is ordered by a court to disclose information, and (d) if a patient discloses 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, a client may file a complaint against the provider with the organization(s) below should the client 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:\_\_\_\_\_\_\_\_\_\_\_

***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#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 listed below according to Privacy Rule, *45 C.F.R.* § 164.508(c)(2)):

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

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#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 listed below according to Privacy Rule, *45 C.F.R.* § 164.508(c)(2)):

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

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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 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_