TODAY'S DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Robin R. Minick LCMHCS, NCC, CCMC, GC-C, PMH-C, CIFST

RR Minick Counseling

177 N Main St.

Waynesville NC 28786 828-246-9751

BIOGRAPHICAL INFORMATION

NAME DATE OF BIRTH

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Town State Zip

EMAIL ADDRESS: \_

Telephone: (H): (W): (C): \_

May we leave messages for you? At home: \_\_\_\_\_\_\_ On your cell: Via email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last four of your social security number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN NAME AND ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

CHRONIC HEALTH PROBLEMS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICATIONS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SURGERIES OR SERIOUS ILLNESS WITHIN THE LAST TEN YEARS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

HAVE YOU RECEIVED A MENTAL HEALTH DIAGNOSIS? YES\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YES, PLEASE SHARE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS COUNSELING EXPERIENCE: YES\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YES, WITH WHOM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN/HOW LONG/OUTCOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY AND/OR OTHER CONTACT PERSON

NAME(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE(S):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RR Minick Counseling, PLLC

177 N Main St.

Waynesville, NC 28786

[rrminickcounseling@gmail.com](mailto:rrminickcounseling@gmail.com)

828-246-9751 phone / 828-649-7161 fax

**Informed Consent:**

Entering a therapist's office for the first can be an uncomfortable experience as there are so many unknowns. However, I would like to welcome you and begin to put you at ease by telling you about the process of therapy and how I work, so that you can give informed consent to enter treatment.

In order for therapy to be successful, it requires active participation by you. There are no instant cures, such as taking medicine for a medical problem. Research and clinical experience confirm that people who fully participate in the process make the most rapid gains. Therefore, I will be asking you to work in partnership with me, to think about your problem in different ways, to work at self-help assignments and activities to make cognitive and behavioral changes.

Furthermore, it is important that you understand that none of the above is a guarantee that your problem(s) will be resolved. If treatment is not progressing satisfactorily, we will discuss additional options for your care. If it is advisable to consider taking psychotropic medications prescribed by a Medical Doctor, Nurse Practitioner, or Physician's Assistant we will work together to secure a referral. By signing this document, you agree that you have been informed of your right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability.

I have read and understand the Therapist-Client Agreement and the HIPAA notices provided and understand that I can request a paper copy of either or both documents. I agree that, during our professional relationship, I will abide by the terms of this agreement and the business policies provided to me.

**I read and understand these passages concerning informed consent. My signature below indicates that I give my complete consent to receive services.**

Signature of Patient: Date: 

Signature of Witness: Date:

Authorization for Emergency Treatment:  In the event that emergency medical care is required for my safety, I hereby grant permission for RR Minick PLLC staff to obtain emergency medical care from a hospital, EMT, or physician if I am unable to do so myself.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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



RRMINICK

# COUNSELING

# Robin R. Minick, LCMHCS, NCC, CCMC, GC-C, PMH-C, CIFST

RR Minick Counseling, PLLC

Phone (828) 246-9751 Fax (828) 649-7161 Professional Disclosure Statement

Master of Science (MS), Clinical Mental Health Counseling Western Carolina University, May 2011

Licensed Professional Counselor Supervisor, #S8937

National Certified Counselor, #282108

Certified Clinical Military Counselor

Certified Grief Counselor

Certified Perinatal Mental Health Counselor

I am licensed as a Professional Clinical Mental Health Counselor Supervisor (LCMHC) in North Carolina and credentialed as a National Certified Counselor (NCC). I am certified through the Licensed Professional Counselor Association of North Carolina (LPCANC) as a Certified Clinical Military Counselor and by the American Institute for Healthcare Professionals (AIHCP) as a Certified Grief Counselor. I recently trained in and was certified in Perinatal Mental Health through Postpartum Support International (PSI) and am also a trained and certified in Internal Family Systems as a Certified in Internal Family Systems Therapist (CIFST).

**Experience, training, and philosophy**

As a graduate student, I completed a year of counseling experience, including a Practicum and Internship with MedWest-Haywood, Carolinas Health Care system, with both Hospice and Palliative Care and with the Behavioral Health Outpatient Program and Behavioral Health Inpatient Unit, serving individuals in bereavement and others in the general population with a focus on active-duty, veteran, National Guard and Reserve military personnel and their families.

I have completed Level I, Level II and Level III training in the Internal Family Systems psychotherapy model and I have been trained in Trauma-focused Cognitive Behavioral Therapy.

Post graduate experience includes fifteen months working in the public mental health field as an outpatient and mobile crisis clinician with Appalachian Community Services. For over four years I worked with Haywood Regional Medical Center Hospice and Palliative Care as a bereavement counselor, serving patients in Hospice care and their surviving family members. I also treated individuals seeking grief counseling who were community referrals. Currently I own and operate a solo private practice.

In my practice one could find individuals of all ages from small children to the elderly. I am trained to do both crisis and comprehensive clinical assessments. I have treated individuals experiencing loss and grief, depression, anxiety, post-traumatic stress, sexual trauma, relationship challenges, addictions, parenting challenges, career concerns, developmental issues, chronic pain, and other challenges in life. I have a special interest in serving those with an Intellectually and Developmentally Disabled (IDD) diagnosis. I also have experience in the diagnosis of mental health disorders based on the DSM-V.

My philosophical model embraces a person-centered approach that includes cognitive-behavioral, rational-emotive behavioral, brief solution-focused, attachment, constructivist, existential and systemic strategies. My work is skills-based and I utilize my training in Internal Family Systems, an interest in positive psychotherapy and my commitment to addressing spiritual issues as appropriate when working with patients. The outcome of psychotherapy cannot be guaranteed; after an initial session, the patient and counselor will determine the best resources for the needs that brought the individual to seek counseling and if work with this counselor is not the best fit a referral to another professional will be made as appropriate. This counselor commits to working within the scope of her training and expertise, to abide by strict ethical standards, to transparency in the counseling process and to ensuring that at no time is she working to meet her own needs but is always focused on supporting the patient in the meeting of their needs.

**Sessions, fees, and billing information**

Sessions are generally 53-55 minutes in duration with shorter or longer periods negotiable as indicated and appropriate. Fee for a Comprehensive Clinical Assessment is $150. Fee for a 53-55-minute session is $120.00. All payments are due at time of service. If 24-hour notice is not provided a missed visit fee will be billed to your account. We are happy to bill insurance for your appointments and require certain information from your insurance company to be able to do so.

**Confidentiality**

State law and professional ethical standards protect privacy and confidentiality. Records are maintained and stored in a manner than assures confidentiality. Information shared by the patient with the counselor is held in strictest confidence and will not be disclosed without the written consent of the patient, with limited exceptions. Confidentiality is not legally or ethically guaranteed in life-threatening situations (harm to self and/or others) involving the patient and/or other individuals or in situations when a child or elderly person is, has been or will be neglected or abused or under a court order (a subpoena is not a court order).

**Complaints**

Clients are encouraged to discuss any concerns with me. A complaint may be filed against me with the organization below should you feel I am in violation of any code of ethics. I abide by the ACA Code of Ethics which can be found at the following web address: http://www.counseling.org/resources/aca-code-of-ethics.pdf



North Carolina Board of Licensed Professional Counselors

P.O. Box 77819

Greensboro, NC 27417

Phone: 844-622-3572 or 336-217-6007

Fax: 336-217-9450

Email: lpcinfo@ncblpc.org

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

**Patient Date**

**Counselor Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Robin R. Minick LCMHCS, NCC, CCMC, GC-C, PMH-C, CIFST**

RR Minick Counseling

177 N Main St.

Waynesville, NC 28786

rrminickcounseling@gmail.com

Phone: 828-246-9751 | Fax: 828-649-7161

Financial Considerations

My standard fee is $150.00 for an Initial Diagnostic Evaluation and $120.00 for a 53-55-minute therapy session. All fees are due at time of service. Acceptable forms of payment include cash, checks, and debit/credit cards. A processing fee of three percent of your fee will be added to all payments made with a credit card.

If you are unable to keep an appointment, please give 24-hour advanced notice. Otherwise you will be charged $60.00 for the missed session.

**I read and understand these passages concerning informed consent and financial considerations. My signature below indicates that I give my complete consent to receive services.**

Signature of Patient: Date:

Signature of Witness: Date:

\*SIGN ONLY IF YOU ARE USING INSURANCE\*

I authorize Robin R. Minick, LPCS, NCC, CCMC, GC-C, PMH-C, CIFST to file for my third-party insurance benefits for services provided to me or to my minor child. I authorize that the insurance benefits be made payable directly to RR Minick Counseling, PLLC. If my insurance policy prohibits assignment of benefits to a doctor or a treatment facility, I accept responsibility for all charges associated with my care, or the care of my minor child and I understand that services provided are not eligible for a fee reduction. Further, I agree to pay any balance that remains after payment of insurance benefits. A photocopy or electronic version of the assignment shall be considered as effective as the original. I authorize the release of my protected health information, of that or my minor child, for the purpose of filing for my insurance benefits, including release of information relating to: diagnosis and/or treatment of alcohol or substance abuse as protected by Federal Substance Abuse Confidentiality Regulations (CFR 42, Part 2), the diagnosis and/or treatment of psychiatric care and/or psychological assessment, and the diagnosis and/or treatment regarding human immunodeficiency syndrome (HIV) or AIDS-related conditions as protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFS, Parts 160 & 164. I further authorize the release of information to utilization review organizations or agencies that provide managed care services for my insurance benefits.

All the information I have provided is correct to the best of my knowledge, I agree to the conditions above\*

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| \*SIGN ONLY IF YOU ARE NOT USING INSURANCE\*  Insurance Decline: 1 request in accordance with HIPAA (1996), 45CR 164.522 that Robin R. Minick LCHMCS, NCC, CCMC, GC-C, PMH-C, CIFST NOT contact my insurance carrier. I understand I will not be eligible for a reduced fee and will be responsible for payment in full at the time of service. Signature: |

RR Minick Counseling

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Waynesville, NC 28786 rrminickcounseling@gmail.com

828-246-9751 phone / 828-649-7161 fax

Confidentiality

The confidentiality of client information is protected by both State and Federal Laws and Regulations. I am sensitive to and have an obligation to protect your right to privacy and am committed to holding confidential information that you give me. I cannot acknowledge my professional relationship with you to any person, including your family and friends without your written authorization. Of as an exception listed in the Notice of Privacy Practices brochure. I may discuss your situation with other professionals as part of your treatment process and to ensure that you are given the best possible care; however, will only do so within the guidelines of HIPAA, C.F.R. 42 and NC General Statutes.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients Rights

As a client of mine, your rights are outlined in Your Rights as a Consumer brochure. A copy of this brochure can be located at my office.

 If you have a concern regarding your privacy, please contact me at 177 N Main St, Waynesville, NC 28786 or call 828-246-9751.

|  |  |
| --- | --- |
| Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |

Consumer Complaints

If you have a complaint about services that you cannot resolve by speaking with me, you may speak directly with the consumer complaints department at Smoky Mountain Center.

Privacy Practices

I hereby acknowledge that I received and have been given an opportunity to read a copy of Notice of Privacy  Practices from the office of Robin R. Minick, LCMHCS, NCC, CCMC, GC-C, PMH-C, CIFST. I hereby understand if I have questions regarding the notice of my privacy rights, I may contact Robin Minick, LCMHCS, NCC, CCMC, GC-C, PMH-C, CIFST at 828-246- 9751. If you have a concern regarding your privacy, please contact me at 828-246-9751.

|  |  |
| --- | --- |
| Signature of Patient: | Date: |
|  |  |
| Signature of Witness: | Date: |

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name Date of Birth



Client Medical Record # Client MCO#



I hereby authorize

(Client or Personal Representative)

RR Minick Counseling, PLLC to disclose specific health information

(Name of Provider/Plan) from the records of

the above-named client to:

(Recipient Name/Address/Phone/Fax)

for specific purpose(s):

Specific information to be disclosed:

I understand that this authorization will expire on the following date event or condition:

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

(initials required for this section) I understand that by initialing this section, if my record contains information relating to HIV infection, AIDS or AIDS-related condition this disclosure will include that information. By not initialing this section, such information may not be released. Release of this information occurs in accordance with NCGS 130A-143

(initials required for this section) I understand that by initialing this section, if my record contains information relating to



alcohol abuse, drug abuse, or genetic testing this disclosure will include that information. By not initialing this section, such information may not be released. Release of this information occurs in accordance with 42 CFR Part 2.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. I further understand that I may request a copy of this signed authorization.



(Signature of Client) (Date) (Witness-If Required)



(Signature of Personal (Date) (Personal Representative Relationship/Authority)

Representative)