

Vida Counseling, PLLC

www.drportela.com

Dr. H Portela, LPC, NCC, ACS

LPC 4935 ♦ NCC 210715

6512 Six Forks Road, Suite 403B. Raleigh, NC 27615

Tel: 919.368.5207 ♦ Fax: 919.882.9505

Consent to Treatment

Client: _____ Birthdate: _____

I do hereby seek and consent to take part in treatment with Dr. Heloisa H. Portela, LPC. I understand that developing a treatment plan with this health care provider and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the health care provider. I know that I may stop treatment with the health care provider at any time.

I acknowledge that keeping of regular appointments is the most effective means of scheduling therapy. I understand that the time scheduled for the therapy appointment is reserved exclusively for me/my child. In light of this, appointments should be kept. If for some reason there is a need to cancel an appointment, **I will call Dr. Heloisa Portela with 48 hours in advance.** I understand that I will be charged for sessions that are not canceled 48 hours prior to their schedule time (be aware that insurance companies do not reimburse these).

I am aware that payment for each session is due at the time the session is held. I also understand that I have the option to use my health insurance in order to cover the counseling treatment fee. My health care provider can be responsible for filling the bill directly with my health insurance for the services she provides. In such instances, my health insurance company may inquire about the type(s), cost(s), date(s), and information of any services or treatments I/my child receives. My therapist will need a copy of the insurance card in order to do this.

It is my responsibility to bring my current insurance card to Dr. Heloisa Portela when a new card is issued, to confirm that they have out-of-network counseling benefits, and double check the co-pay value for each session. If my insurance coverage ends or lapses for any reason or if it does not cover the services provided, I will be responsible for full payment of services. The fee for each session (45-50 min.) is \$125.00. A discount may be given to clients who opt to file insurance for themselves or who pay out-of-pocket for their treatment.

By signing this form I am agreeing to let my healthcare provider use my or my child's information in order to fulfill billing issues. The Notice of Privacy Practices explains in more detail my rights and how my healthcare provider may use and share information. **If I decline to sign this consent form agreeing to what is in the Notice of Privacy Practices, I can not receive treatment.**

I have had a chance to discuss all of these issues, and the risks and benefits of treatment. I have also read and understood the Notice of Privacy Practices.

My signature below shows that I understand and agree with all of the above statements.

Signature Of Client or Legal Guardian

Date

I, the health care provider, have discussed the issues above with the client (and/or his or her legal guardian). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature Of Health Care Provider

Date

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Client Information Sheet

Client's Full Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home _____ Cell _____ Work _____

Age: _____ Birth Date: _____ SSN # _____ - _____ - _____

Marital Status: _____ Driver's License#: _____

Employer Or School & Grade (If Student): _____

Referred By: _____ Phone: _____

Person Who Does Not Live With You To Contact In An Emergency:

Name: _____ Phone: _____

May I contact this person to thank them for referring you? (Yes) (No) Please initial: _____

Insurance Information

Insurance Company: _____ Name of Insured: _____

Insured's SSN#: _____ Insured's D.O. B.: _____

Insured's Policy #: _____ Insured's Group #: _____

Insured's Employer: _____ Amount of Copays: _____

Insured's Relationship To Client: _____ Authorization #: _____

If your counseling is being paid for through an employee assistance program, please list authorization number and how many sessions are being authorized.

EAP Company: _____ Authorization #: _____ # of Sessions: _____

To Be Completed By Therapist

Primary Diagnosis _____ Secondary Diagnosis _____

Treatment Agreement

Please Initial:

Co Payments Are Due At The Time Of Service. _____

I Hereby Assign Payment Of Insurance Benefits Directly To Heloisa Portela, Ph.D., LPC, NCC, ACS. While Dr. Portela will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay. _____

It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied I will be responsible for all charges. _____

I understand that if my portion of the bill is not paid within 90 days from the last date it was incurred a letter will sent giving me 14 days to pay my account or to arrange for a payment plan. If I do not respond I will be sent to collections. _____

I understand that a 1% interest will be added to my portion of the bill that remains unpaid after 30 days. _____

Fees are \$ _____ for each 45 minute session. _____

Cancellation Policy: Vida Counseling requires a full 48-hours notice for cancellation or rescheduling of an appointment. I understand that I will be charged \$75 for missing an appointment or not giving at least 48 hours prior notice to cancelling an appointment. _____

I understand that my insurance company does not cover missed appointments and that I will be fully responsible for any appointment not canceled with at least 48 hour notice. _____

I have received the treatment agreement and disclosure statement. I understand and agree to abide by my financial responsibilities. I understand that information will be released to my insurance company, including a diagnosis code, so they can cover my sessions with Dr. Portela. Any charges that my insurance company does not cover I am responsible for. _____

Signature of Client or Legal Guardian

Date

To enable accurate and confidential services please complete/initial the following:

Messages regarding appointments may be left on my voice mail. _____Yes _____No

Email may be used to communicate with me. _____Yes _____No Email address _____

I understand that there are limitations to the use of email technology, and confidentiality cannot be guaranteed. I agree to hold Dr. Portela harmless if there is a technical or communication failure resulting from my choice to communicate with her by email. _____

I understand that fax transmissions are utilized for exchange of information with billing company and other providers (if applicable). _____

The following individuals may schedule and or confirm appointments:

Medical/Mental Health History

What brings you to seek counseling? _____

Please check individual items you want to address. Please circle the two most important, to address first:

Sexual Concerns	Fears	Bowel Trouble	Self-Esteem
Concentration	Guilt	Stomach Trouble	Temper
Hopelessness	Self-Control	Sexual Problem	Relaxation
Depressed	Harm to Others	Drug Use	Finances
Harm to Self	Impulsivity	Alcohol Use	Work
Suicidal Concerns	Hyperactive	Headaches	Motivation
High Energy	Attention Difficulties	Memory	Legal Matters
Low Energy	Sleep Problems	Thoughts	Career Choices
Anger	Dreams	Abuse	Education
Temper	Nightmares	Trauma	Making Decisions
Nervousness	Health Problems	Shyness	Meaninglessness
Anxiety	Appetite/Weight	Crying Spells	Unresolved Grief
Stress	Eating/Food Trouble	Unhappiness	Spiritual Concerns
Panic			

Please check relationship items you want to address. Underline those you feel apply to another family member. Please circle the two most important to address first:

Marriage	Parenting	Recreation	Friendships
Separation	Children	Infidelity/Affairs	Holding Other Down
Divorce	Housing	Physical Fighting	Conflicting Schedules
Intimacy	Finances	Common Interests	Problem Solving
In-Laws	Sexual Desire	Showing Appreciation	Loneliness
Relatives	Agreeing On Chores	Trusting Each Other	Common Goals
Jealousy	Sexual Performance	Affection	Verbal Fighting
Use Of Time	Spouse's Cleanliness	Communication	Having Fun Together

Have you, your partner/spouse or children ever previously seen a therapist? If so, what year? Who did you or they see and for what reason? About how many meetings did you have? Was the experience helpful? How so?

Did you have any serious accidents/injuries/illnesses involving such things as (circle): convulsions, high fevers, loss of consciousness, fainting, headaches, allergies, chronic fatigue, head injuries, ear problems, or meningitis? Explain:

Did you ever require hospitalization or have been treated for serious illness or disease? If so, please explain:

Current Internist/Family Practitioner's name and name of practice:

Name: _____

May I contact your doctor to collaborate with him/her? (Yes) (No) Please initial: _____

Address: _____

Phone Number: _____

When was your last complete physical? _____

Do you currently have any health problems? _____

Are you currently on any medications? If so, please list what they are, dosage, and what the medication is treating: _____

Is there a family history of mental illness or substance abuse? If so, please explain.

Have you ever been physically, emotionally or sexually traumatized? Have there been domestic violence issues in the home where you grew up/live? If so, please provide whatever details would be relevant to my understanding of your life:

Have you ever attempted suicide or had a plan to harm yourself? When? What was the plan?

Do you currently have any known thoughts or feelings of wanting to physically harm yourself? If so, please describe.

Do you currently have any thoughts or feelings of wanting to physically harm someone else? If so, please describe and include the person's name.

Do you currently have or have previously been diagnosed with an eating disorder? If so, please describe.

Have your eating and/or sleeping habits changed in the last 3 months? Please describe.

Please list any significant life traumas and the year they occurred:

List any significant and positive life influences:

Please describe your current work/academic/professional functioning. Do you work or go to school? Where?

Please describe your social relationships. Do you have friends? Go out for fun? Socialize?

Do you participate in a religious or faith-based group? How involved are you in it?

What are you looking to change in your life? How would you like your life to be different?

What are your hobbies and interests?

What are your main concerns about yourself? What are your goals for counseling?

What are some things you expect from me in terms of our working together?

Substance Use and Behavior History

Substance / Activity	Amount / Frequency
<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Tobacco	
<input type="checkbox"/> Drugs	
<input type="checkbox"/> Marijuana	
<input type="checkbox"/> Medications (not as prescribed)	
<input type="checkbox"/> Reckless behavior	
<input type="checkbox"/> Gambling	
<input type="checkbox"/> Violent history	
<input type="checkbox"/> Convictions for felonies	
Do you or does your spouse, friend, or loved one believe any of these substances or behaviors are a problem in your relationship or work life?	(Yes) (No)

Describe your current and past use of alcohol/drugs.

Have you ever been treated for substance abuse? If so, when, where, and for what substances?

Your Family: Now

If partnered, for how long: _____ If married, since when: _____

- If separated, divorced or a partner has died, please explain the circumstances. If you have children, please explain custody & visitation schedule (if any) and communication status between you and former spouse.
 - Please give a brief history below as to when you and your partner or spouse first met, and any relevant information about your years together (what life crises or challenges or joys you both have experienced).
-
-
-

Children

First Name	School Grade?	Biological? Yes/No	Lives with you?	Current Age	Male/Female	Describe in one word
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Please use the space below for any relevant information about your children, your marriage, and/or your family:

Who lives in your house? _____

Your Family of Origin

	Mother	Father
Current age, or if deceased, age and cause of death		
Country of Origin		
Religious/Spiritual Affiliation (if any)		
Use three adjectives to describe each parent	1. 2. 3.	1. 2. 3.
Describe your relationship to each parent		
Describe your earliest memory of either parent		
Use three adjectives to describe their marriage	1. 2. 3.	
Length of their marriage		
Caption that describes your family of origin		
Number of siblings		
Your place in birth order		
Were you adopted?		
Divorce and remarriage of your parents:		
Your age at divorce		
Reason for divorce		

Relationship to step-parents, if any	
List any major family of origin problems:	

Siblings:

First Name	Health Status	Biological? Yes/No	Married/ Partnered? Yes/No	Current Age	Male/ Female	Describe your relationship in one word
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Please list anyone else who lived with you or was a memorable caretaker for you as you were growing up:

Name	Current Age	Relationship to You	Health/Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you were adopted, please give any relevant information about biological parent history:

Symptoms & Characteristic List

Please read the following list carefully and check any conditions that you currently experience. Please circle one value for each item according to the following:

0 = not a concern

1 = experiencing **mild** difficulty with an item

2 = experiencing **moderately** difficulty with an item

3 = experiencing **severe** difficulty with an item

0 1 2 3	Depression
0 1 2 3	Mania
0 1 2 3	Anxiety
0 1 2 3	Psychosis
0 1 2 3	Hallucinations
0 1 2 3	Delusions
0 1 2 3	Thinking Problems
0 1 2 3	Cognition Problems
0 1 2 3	Memory Problems
0 1 2 3	Concentration Problems
0 1 2 3	Impulsive Behavior
0 1 2 3	Reckless Behavior
0 1 2 3	Aggressive Behavior
0 1 2 3	Activities of Daily Living Problems
0 1 2 3	Weight Loss Associated with Eating Disorder
0 1 2 3	Substance Abuse/Dependence
0 1 2 3	School Performance Problems
0 1 2 3	Job Performance Problems
0 1 2 3	Social Problems
0 1 2 3	Relationship Problems
0 1 2 3	Marital Problems
0 1 2 3	Family Problems
0 1 2 3	Legal Problems
0 1 2 3	Controlling
0 1 2 3	Regrets Past Actions
0 1 2 3	Disabled
0 1 2 3	Body pains and aches
0 1 2 3	Low motivation
0 1 2 3	Sometimes panicky
0 1 2 3	Dislike for weekends/holidays
0 1 2 3	History of violence
0 1 2 3	Difficulty making friends
0 1 2 3	Regrets Past Actions
0 1 2 3	Jealous
0 1 2 3	Misunderstood
0 1 2 3	Bored
0 1 2 3	Regrets Past Actions
0 1 2 3	Violent impulses
0 1 2 3	Obsessive or intrusive thoughts
0 1 2 3	Repeating compulsive behaviors (like washing hands)

0 1 2 3	Hopelessness
0 1 2 3	Sad
0 1 2 3	Hyperactive/Agitated
0 1 2 3	Insomnia
0 1 2 3	Oversleeping
0 1 2 3	Restless sleep or waking early
0 1 2 3	Nightmares
0 1 2 3	Loss of appetite
0 1 2 3	Restrict Food Intake
0 1 2 3	Increased appetite
0 1 2 3	Rapid weight loss or gain
0 1 2 3	Purges with laxatives
0 1 2 3	Feels fat
0 1 2 3	Frequent crying or feeling weepy
0 1 2 3	Frequently sad
0 1 2 3	Frequently irritable
0 1 2 3	Described as angry by loved ones
0 1 2 3	Feeling empty
0 1 2 3	Feeling abandoned
0 1 2 3	Tired most of the time
0 1 2 3	Loss of interest socially
0 1 2 3	Unable to make decisions
0 1 2 3	Worrying much of the time
0 1 2 3	Described as pessimistic
0 1 2 3	Unable to enjoy usual interests
0 1 2 3	Thoughts of Hurting Self
0 1 2 3	Thoughts of Hurting Others
0 1 2 3	Premenstrual problems
0 1 2 3	Irregular menstrual cycle
0 1 2 3	Teeth grinding
0 1 2 3	Uncomfortably shy
0 1 2 3	Low self-esteem and self-worth
0 1 2 3	Seeing things that are not there
0 1 2 3	Smell odors that are not present
0 1 2 3	Experiences déjà vu
0 1 2 3	Hearing voices
0 1 2 3	Loss of time
0 1 2 3	Disabled
0 1 2 3	Body pains and aches
0 1 2 3	Low motivation

0 1 2 3	Unable to relax
0 1 2 3	Sexual satisfaction low
0 1 2 3	Loss of interest in sex
0 1 2 3	Other sexual concerns
0 1 2 3	Pain with sexual intercourse
0 1 2 3	Problems with pornography
0 1 2 3	Unpleasant dreams (recurring)
0 1 2 3	Gambles to excess

0 1 2 3	Low energy
0 1 2 3	Sometimes panicky
0 1 2 3	Dislike for weekends/holidays
0 1 2 3	History of violence
0 1 2 3	Difficulty making friends
0 1 2 3	Problems with alcohol
0 1 2 3	Problems with drugs / medications
0 1 2 3	Problems with reckless behavior

S.N.A.P.

SNAP gives a snapshot of where you are in treatment, week to week. It helps you and your therapist direct your treatment, to make sure you are getting your needs met, and it helps you make sure you are getting the most out of your time here in treatment.

Strength: something you are born with, something you are good at.

Need: Something you need.

Ability: Something you have learned or are learning to do, something you can do.

Preference: Something you prefer, like.

Example:

Strength: "I am very funny."

Need: "I need to be loved."

Ability: "I can use my voice to ask for what I need."

Preference: "I prefer to be honest with people."

Your turn!!

Strength: _____

Need: _____

Ability: _____

Preference: _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative: _____

Relationship to Client: _____ Phone: _____ Secondary Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor (when applicable). I understand that I am financially responsible for any balance. I also authorize Dr. Heloisa Portela or my insurance company to release any information required to process my claims.

Client Signature

Date