SUSAN INTEMANN LPC, BCB, Fellow

Inner Healing Resources
6604 Six Forks Road Suite 104 Raleigh, NC 27615
Phone: 919-271-4412 Fax: 919-861-8893 Email: sue@innerhealingresources.com

PATIENT HEALTH QUESTIONAIRE

Date: ________/________/________

Name: ______________________________________ Date of Birth: _______/______/_______

Address: ____

______________________________________ Email Address: _____________________

Phone # _______________________ _______________________ _____________________
(home) (work) (cell)

Emergency Contact: ____________________________________ Relationship: ______________

Contact Phone: ____

Primary Care Physician: _____________________________________ Phone: _______________

Address: ____

____

May I contact this person: _______________

Other Care Provider: _______________________________________ Phone: ______________

Address: ____

____

May I contact this person: _______________

Allergies/Medical Conditions: ____

____

____

____

____

The confidentiality of these patient records maintained by Integrated Health Care, State Statutes and Federal Regulations protect LLC. No identifying information or content of these records may be disclosed without the patient's written consent, the disclosure is allowed by a court order, or the disclosure is made to qualified personnel in a medical emergency.

Please indicate any symptoms conditions that you may have experienced for 1 month or longer:

__ feeling sad	__ eating too much/too little	__ loss of interest/pleasure in activities
__ irritable	__ weight gain/loss	__ mood swings
__ sleep problems	__ back or neck pain	__ trouble concentrating
__ crying jags	__ headaches	__ frequent loss of control of temper/anger
__ memory problems	__ fears/phobias	__ preoccupation with order, details, counting
__ boredom	__ confusion	__ avoidance of certain places/activities

Have you ever been diagnosed with:

__ Attention Deficit Hyperactivity Disorder	__ Diabetes: Type I ___ or Type II ___
__ Anxiety	__ Cancer: Type ____________________
__ Asthma	__ Post Traumatic Stress Disorder
__ Heart Disease	__ Obsessive/Compulsive Disorder
__ Pulmonary Disease	__ High Blood Pressure
__ Depression	__ Bipolar Disease
__ Liver Disease	__ Thyroid Disease
__ Arthritis	__ Fibromyalgia (FMS)
__ Borderline Personality Disorder	__ Chronic Fatigue Syndrome
__ Gastro-Intestinal Disease	__ Allergies: ________________________

__ Abuse of Alcohol or other Drugs: (specify) ____

__ Dependence on Alcohol or other Drugs: (specify) ____

__ Other: (specify) ____

Have you ever been abused or harmed physically/sexually/emotionally? Yes ___ No ___

Have you ever had an injury to your head? Yes ___ No ___ If yes, when? ____________________

Have you ever tried to harm yourself? Yes ___ No ___ Date of most recent event: __________

Please list your current medications prescribed by your doctor: (name of drug/dose/how often)

____

____

____

____

Please list non-prescription drugs that you are using or have used, including over the counter medications, alcohol and other drugs. Include use of marijuana, nicotine and caffeinated products.
(name of drug or substance/quantity/how often)

____

____

____

Briefly, please describe the situation or symptoms that bring you to therapy at this time.

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

PLEASE INITIAL AND DATE THE BOTTOM OF EACH COMPLETED PAGE.

______________ ______/______/______
Initials Date

Professional Disclosure Statement
(Information and Informed Consent)
Susan Intemann, LPC, BCB, Fellow

The following information is provided to help you understand my background and the counseling experience.

I am a Licensed Professional Counselor in the State of North Carolina (License #5108). I have been in private practice as a Licensed Professional Counselor in the State of North Carolina since December 2005. I hold a Master of Liberal Arts from NC State University, with a focus on Training and Development and Health Behaviors/Health Education (2000). Pursued graduate studies in Counseling, at NC State University (2002-2004). I Completed all necessary coursework as set forth by the Biofeedback Institute of America for EMG Biofeedback (1999). BCIA-C, certified Biofeedback practitioner. I am a graduate of UNC's Mindfulness Program, through the Department of Integrative Medicine. I have also received extensive training in Critical Incident Response.

Experience:
Over the years I have worked in both the private and public sector. In the early 80's I was a Child Protective Caseworker, in New York. When I moved to North Carolina in the early 90's I was employed by the NC Division of Parks and Recreation, in a position that entailed working with many aspects of Human Resource Development, including employee safety, training programs, community service worker program administration, and disaster response and recovery. Prior to pursuing private practice as a counselor, I was the Treatment Coordinator in a chronic pain facility and than worked in an outpatient physical therapy clinic as a Biofeedback Practitioner, treating mainly persons suffering from chronic pain. I am a contract provider for the Department of Defense, Military and Family Life Consultant. I am past president of the North Carolina Biofeedback Society and serve as a consultant to the Education Section of the American Association for Applied Psychophysiology and Biofeedback. I am also an active member of The American Academy of Pain Management and the Licensed Professional Counselors Association of North Carolina.

Counseling process:
Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. Counseling includes your active participation. It is based on trust, respect and mutually identified goals. I may ask you to do homework and exercises to promote insight and behavior changes. Together we will formulate a treatment plan to decide on goals and specific ways to reach them.

My approach to counseling is based on individual needs, it is both eclectic and educational. I often take a psychoeducational approach, teaching people specific skills in tackling problems so that you acquire a range of helpful tools for maintaining wellness..

I rely heavily on approaches from Aaron Beck's "Cognitive Therapy," Albert Ellis's 'Rational Emotive Therapy." I use Biofeedback as an adjunct to many of my treatment plans. Especially in the case of chronic pain, improvement can result from awareness and self regulation of involuntary actions that can aggravate and perpetuate the conditions.

I work with adults who experience anxiety disorders, depression or difficulty coping with stressful life events. My focus is working with adults, children and adolescents on the multifaceted issues and concerns so often associated with chronic pain conditions. Although our sessions maybe very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling sessions that you arrange with me except in case of an emergency. As a client (or parent of a client), you are in complete control and may end our counseling relationship at any time.

If I believe, in my professional opinion, that I am unable to help you, I will recommend other professionals with skills that may better fit your needs.

Sessions, Fees, Reimbursement:
The initial evaluation will be 70 minutes in duration. Duration of subsequent sessions will range from 45-60 minutes (generally dependent on insurance carrier). Together we will decide upon the frequency of sessions. **This time is specifically reserved for you. As a courtesy to myself and other clients please notify me at least 24 hours in advance if you are unable to keep a scheduled appointments. No-show fees are charged for appointments cancelled or broken without 24 hours advance notice. The no-show fee is $85.00.**

Occasionally, situations may arise in your life that lead you to desire contact between scheduled sessions. I am happy to do brief problem-solving over the telephone. Beyond five minutes, however, I will need to bill the time at my normal rate. For example, a 25 minute conversation would be billed. Fees for time spent in this way are more than likely not covered by your insurance. Written and/or telephone calls that are done outside of our sessions will be billed for in the same manner (for example, if I write a letter for you that takes 25 minutes of my time).

I will be charging $150 for the initial assessment and $125 for subsequent sessions. The fee also includes my time on your behalf to do record-keeping, insurance filing and preparation for your sessions. I ask that you pay at the conclusion of each visit unless other arrangements have been made. If you are not covered by a health insurance plan or do not wish to file for reimbursement, I will discuss the option of providing counseling services at a mutually agreed upon fee.
Cash, personal check, MasterCard, Visa and American express are accepted.

If you have health insurance, please call to see if your provider covers mental health care. I am in-net-work with several insurance companies. Many insurance companies do offer out-of-net-work benefits. I will inform you of the diagnosis I plan to render before I

submit it to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Confidentiality:
Information that is shared during counseling, including my records, is private and confidential. Records are my property, but you have a right to the information in your record. You may have a copy of your records within thirty days of written request. Most communications are confidential, but the following limitations and exceptions do exist (legally and ethically): (1) you provide me with your consent to release information; (2) I have reasonable suspicion that you are a threat to yourself or others; (3) you disclose abuse or neglect of a child, elderly person, or disabled person; (4) I am ordered by the court to disclose information; (5) you involve me in a lawsuit and I need to release specific information on order to receive compensation for services rendered.

Court Appearances, testimony, depositions, or expert witness:
The charge is $1000.00 per day or any part thereof.

You must tell me at the initial evaluation if you are filing for disability, workers compensation or are involved with any litigation or pending litigation for which my services will be required. Additional time required will be charged at a rate of $100 per hour, which is not billable to health insurance.

Complaint Procedures:
If you are dissatisfied in any way, please inform me immediately. This will make our work together more efficient and effective. If you think you have been treated unfairly or unethically by me and cannot resolve this problem with me, you can contact the North Carolina Board of Licensed Professional Counselors at 893 US Highway 70 West, Suite 202, Garner, NC 27520-2597, 919-661-0820.

_______________________ __________________________
Client's Signature Date

_______________________ __________________________
Therapist Signature Date

SUSAN INTEMANN LPC BCB, Fellow

Susan Intemann, LPC, BCB, Fellow Licensed Professional Counselor
Inner Healing Resources
6604 Six Forks Road Suite 104 Raleigh, NC 27615
Phone: 919-271-4412 Fax: 919-861-8893 Email: sue@innerhealingresources.com

CONSENT FOR MEDICAL INFORMATION AND RECORDS

I hereby authorize Susan Intemann to contact the following individuals and/or agencies for the release of information and records regarding my treatment. I understand the information will be used in my best interest for the sole purpose of my health care treatment. I also understand that the exchanged information will be handled in a confidential manner. This consent will expire at the end of my treatment.

Patient's Name: ______________________________

Date of Birth: ______________________________

Patient's SS#: ______________________________

INDIVIDUALS OR AGENCIES RELEASED FROM

____
____
____
____
____
____

INFORMATION AND RECORDS RELEASED TO

____
____
____
____

____
Patient Signature

____
Parent or Legal Guardian Signature if Patient is a Minor

______________________ ______/______/______
Witness Signature Date

Susan Intemann, LPC, BCB, Fellow

inner healing resources

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present and future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. However, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me.

II. HOW WILL I USE AND DISCLOSE YOUR PHI.

I may use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others will not. Below you will find the different ways I may use or disclose your PHI.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations do not Require Your Prior Written Consent.

I may use and disclose your PHI without your consent for the following reasons:

1. **Treatment.** I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to him/her for coordination of treatment.
2. **Health Care Operations.** I may disclose your PHI to facilitate the efficient and correct operation of my practice. Example: I may provide your PHI to my attorneys, accountants, consultants, and others to make sure I am in compliance with applicable laws.
3. **Payment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for health care services I have provided to you.
4. **Other Disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **If I determine that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others.**
2. **To contact you, without your prior authorization, to provide appointment reminders or information about other health-related benefits and services that may be of interest to you.**
3. **If disclosure is otherwise specifically required by law.** Example: when I am court ordered to release information.
4. **If I suspect abuse or neglect of children or disabled or elderly adults.**

C. Certain Uses and Disclosures Allow You to Have the Opportunity to Object:

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in previous sections I will request your written authorization before using or disclosing your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

A. **The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in my possession, or to get copies of it. However, you must request it in writing. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. **The Right to Choose How I Send Your PHI to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work rather than your home address) or by an alternate method (for example, via email instead of regular mail). I am obliged to agree to your request providing that I can give you the PHI in the format you requested without undue inconvenience.

D. **The Right to Get a List of the Disclosures I Have Made.** You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented (i.e. those for treatment, payment, or health care operations). Neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of the disclosures within 60 days of receiving your request. The list will include the date of the disclosure, to whom the PHI was disclosed, a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. **The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My written denial must state the reasons for the denial and explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the changes to your PHI.

F. **The Right to Request a Paper Copy or Email of This Notice**

IV. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you feel I have violated your privacy rights, or if you object to a decision I made about access to your PHI, you may file a complaint with me or you may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. If you file a complaint about my privacy practices, I will in no way take any retaliatory action against you.

IV. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on April 14, 2003.

I ACKNOWLEDGE RECEIPT OF THIS NOTICE

Patient Name:______________________ Date:___________Signature:_____________________