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

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

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

__ Other: (specify) _____

Have you <u>ever</u> 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

LCMHC PROFESSIONAL DISCLOSURE STATEMENT

Susan P Intemann, LCMHC

Phone: (919) 217-4412

I am pleased to be able to work with you as your counselor. The following is some information that may be useful for you to know as we begin working together.

I received my LPC (Licensed Professional Counselor) Licensure in North Carolina in December 2005. (#5108) This title has since changed to LCMHC (Licensed Clinical Mental Health Counselor. I hold a Master of Liberal Arts degree from NC State University, with a concentration in Training and Development and Health Behaviors/Health Education (2000). Pursued graduate studies in Counseling, at NC State University (2002-2004).

I am a Certified Practitioner in Eye Movement Desensitization and Reprocessing (EMDR) from EMDR International Association (2012). In 2016, I received a Certification as a Clinical Trauma Professional through the International Association of Trauma Professionals. In 2018 I received my certification as a Hypnotherapist from The National Guild of Hypnotists.

In addition, I am Board Certified Biofeedback, Senior Fellow (1999). Biofeedback Certification International Alliance. In 2018 I received my certification as a Hypnotherapist from The National Guild of Hypnotists.

Experience:

I have been in private practice in North Carolina as an LCMHC since 2005.

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 relocated to North Carolina in the 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, ADA compliance, 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 then worked in an outpatient Physical therapy clinic as a lead Biofeedback practitioner, treating mainly persons suffering from chronic pain.

I have been employed by the Department of Defense as a Military and Family Life Consultant.

I also served in a volunteer position for the American Red Cross, as the Disaster Response Coordinator. Most recently I served as a part of a Clinical Support team, North Carolina First Responder Peer Support.

Counseling Approach

My approach is based on individual needs, integrating a number of different therapeutic styles and modalities, depending on what fits the best with the client and situation. My approach to therapy is holistic. I rely on solution focused approaches, relying heavily on the mind-body connect, such the work of Francine Shapiro's Information Processing model EMDR. Somatic psychology and body-based psychotherapy are important to my approach. This includes modalities such as EMG Biofeedback. The work of Stephen Porges and somatic psychology is also an integral part of my therapeutic approach. I also use Cognitive Therapy, based on Aaron Becks work, emphasizing the link between thoughts, feelings and behaviors.

I will explain the basic principles of all these approaches and encourage you to do some research on your own.

Counseling is a personal exploration and may lead to major changes in life perspectives and decisions. It is based on trust, respect and a commitment to mutually identified goals. The process of change is exciting but challenging. Changing thoughts, actions and behaviors rarely comes easy but usually takes perseverance and practice over time. I may ask you to do homework and exercises to promote insight and behavior changes. I believe all the answers lie within you, and together, we will create a plan to decide on goals and ways to reach them.

Population Served

In my private practice I work with adults challenged by symptoms associated with depression, anxiety, trauma related experiences, chronic pain and illness**.**

Sessions, Fees, Reimbursements

I am currently in network with Blue Cross Blue Shield, Aetna, and TriCare.

All sessions are 60 minutes. I will be charging $145.00 per session. 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 your co-pay, deductible or private pay at the beginning of each

session unless other arrangements have been made. I accept checks, cash and credit cards as well as most HSA's.

Some insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that there is a diagnosis of a mental health condition. I will inform you of your diagnosis before I submit your diagnosis to the insurance company. Any diagnosis made will become part of your permanent record.

As a courtesy to myself and other clients please notify me at least 24 hours in advance if you are not able to keep your scheduled appointments. Missed appointment fees are charged for appointments cancelled or broken without 24 hours advanced notice. The missed appointment fee is $100.00.

Confidentially

Information that is shared during the counseling session, including my records is private and confidential. It is accessible to you within thirty days upon written request. In order to release information for any other reason, you are required to sign a consent for release of information form. Most communications are confidential, however, there are circumstances in which I cannot guarantee confidentiality, legally or ethically: * When I believe you intend to harm yourself or another person * When I believe a child, elder person or disabled person has been or will be abused or neglected and when DSS is involved * When you direct me in writing, to disclose information to someone else * I am ordered by the court to disclose information.

Court Appearances, Testimony, Depositions, Reports or Expert Opinion

You must sign a release of information before any information is released. For legal involvement such as depositions, expert opinion, court appearances, testimony, I charge $850.00 per day or any part thereof or $1200 per day or any part thereof when less than one weeks' notice (including subpoena) is given. These services are NOT reimbursable through insurance.

Dual Relationships / Contact Outside of Counseling

Our sessions will concentrate exclusively on your concerns. In order to serve you better and maintain the ethical standards of my profession, our relationship will need to remain strictly professional. Any social contact outside our counseling sessions is discouraged. Phone calls between sessions are limited to appointment scheduling or rescheduling or to

urgent matters related to your health and safety. Messages left on my voice mail are confidential and cannot be accessed by anyone else.

Complaint Procedures

I abide by the ACA Code of Ethics (http://www.ccounseling.org/Resources/CodeOfEthics). If you are dissatisfied with any services provided by me or feel you have been treated unfairly or unethically, I urge you to discuss your concerns with me, so that we can work to resolve them together. If we cannot resolve the issue(s) together, please contact the North Carolina Board of Licensed Clinical Mental Health Counselors at P.O. Box 77819, Greensboro, NC 27417, 844-622-3572; www.ncblmhc.org for clarification of your rights to file a complaint.

We agree to these terms. Please sign and date. A copy will be provided to you.

_____ _____

Client Date

_____ _____

Counselor 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:_____