PALMETTO
COUNSELING & CONSULTING

PCC Intake Form & Services Agreement β

IMPORTANT: TO SECURE YOUR INITIAL APPOINTMENT AND ENSURE YOU HAVE MAXIMIUM TIME WITH YOUR PROVIDER, PATIENT MUST COMPLETE PCC INTAKE FORM AND SERVICES AGREEMENT BY EITHER OF THE FOLLOWING METHODS:

1. VISIT WWW.PCCRH.COM TO DOWNLOAD HARDCOPY PDF VERSION OF PCC INTAKE FORMS. PLEASE PRINT, COMPLETE ALL FORMS, SCAN, AND EMAIL COMPLETED INTAKE FORM AND SERVICES AGREEMENT TO INFO@PCCRH.COM (OR SECURE FAX 803-329-5830).

2. PLAN TO COME IN TO THE OFFICE TO COMPLETE ALL FORMS AND PAPERWORK AT LEAST 30 MINUTES OR MORE BEFORE SCHEDULED APPOINTMENT TIME WITH COMPLETED FORMS AND VALID DRIVERS LICENSE.

PLEASE NOTE: FAILURE TO DO THE ABOVE MAY RESULT IN YOUR APPOINTMENT BEING CANCELLED OR RESCHEDULED.

Policies and procedures included in this signature packet:

- PCC Intake Forms - B
- Professional Disclosure Statement (Provisionally Licensed Therapist)
- PCC Informed Consent for Treatment (Provisionally Licensed Therapist)
- Patient / Client's Rights
- Palmetto Counseling Financial Policy
- PCC Consent for E-Mail and Electronic Means of Communication
- PCC Telehealth Informed Consent and Addendum
- PCC Informed Consent for In-Person Services During COVID-19 Public Health Crisis
- Receipt and Acknowledgement of HIPAA Notice of Privacy Practices [*Available at]:*
- https://www.pccrh.com/wp-content/uploads/2018/11/Palmetto_Counseling_Privacy_Practices.pd
- For patients who do not have computer / internet access hardcopy is available upon request

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PCC Intake Form & Services Agreement

Today's Date:_____

Patient First Name:_____ **MI:**_____ **Last Name:**_____

Patient Date of Birth:_____ **Social Security #:**_____ **Gender:**_____

Ethnicity:_____ **Marital Status:**_____

Patient Driver's License #:_____ **State Issued**_____

Patient Address:_____ **City**_____ **State**_____ **Zip Code**_____

Home Phone #:_____ **Cell Phone #:**_____ **Work #:**_____

Email:_____ **Ok to leave message? Y** ☐ **N** ☐

Preferred Contact Method for Appointment Reminders: Electronic Text ☐ **Email** ☐ **Telephone Msg** ☐

☐ **Check if patient is a minor**

Legal Guardian (skip if not applicable):

Custody: ☐ **Mother** ☐ **Father** ☐ **Joint** ☐ **Other**

*Note: If minor, parent / legal guardian(s) must provide PCC copies of the following legal documents if separated, divorced, or legal guardianship:

- Terms of Legal Separation
- Temporary and/or Final Custody & Divorce Decree
- Legal Guardianship

Important Note: If parent / guardian of minor patient is unable to provide PCC copies of legal documentation at time of intake, by signing PCC Intake Form and Services Agreement, presenting parent / guardian herby acknowledges you have legal authority to make medical & mental health decisions on behalf of child and further confirms you take financial responsibility for child's treatment independent of any other parent or party's consent.

Presenting Parent / Guardian Initials_____

Emergency Contact List / Family Members involved in Patient's Treatment

Emergency Contact Name:_____**Relationship**:_____

Emergency Contact Address:_____**City**_____**State**_____ **Zip Code**_____

Emergency Contact Phone #:_____ **Email**_____

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AGREEMENT TO PARTICIPATE IN SERVICES AND CONSENT FOR TREATMENT

Disclosure law requires Palmetto Counseling & Consulting Services, LLC obtain your signature acknowledging that you were provided with this information. Your signature below indicates that you have read or listened to the information in this Services Agreement and in the accompanying handouts, that you understand it and agree to abide by its terms during your professional relationship with Palmetto. It also serves as an acknowledgment that you have received and read or listened to the Notice of Privacy Practices form and Palmetto's fee for service model. If you have any questions, please feel free to discuss them with us before signing this Services Agreement. These policies may be updated at any time.

I hereby authorize Palmetto Counseling & Consulting Services, LLC to provide mental health services including the evaluation, treatment, or providing consultation to myself or minor child (if applicable). I understand that my medical record may contain information regarding HIV/AIDS, substance abuse, mental health, or other sensitive information.

Your signature indicates that you understand and agree no insurance claims will be filed as your services are being provided by a provisionally licensed clinician who does not participate in private commercial or 3rd party-payor insurance networks. Subsequently, by signing you accept responsibility for payment of fees in accordance with the terms and conditions of a 'fee for service model' (full payment is expected at time of service).

An electronic copy of this agreement may be substituted for and will be legally binding as the original agreement.

This agreement constitutes informed consent without exception.

_____

Patient Name [Please Print]

_____

Patient Signature Date

_____

Parent / Legal Guardian Signature [If applicable] Date