# Dori C. Luke, MSW, LCSW, SEP, BASE
# Self-Full Psychotherapy, PC
## *Personal Information Form*

Date: _____

Full Name: _____ Nickname:_____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

***Please circle the phone number(s) that is best for leaving you confidential messages, if need be.***

Date of Birth: _____ Age: _____ Gender: _____

Relationship Status (circle one): Married Divorced Separated Single Widowed Unmarried Couple/Partnered

Ethnicity (circle one): African-American Caucasian Hispanic Asian Native American Other _____

Religion: _____ How many people are in your household? _____

How many years of education have you completed? _____

Employer: _____

Employer Address: _____

Occupation:_____

Source of Income (circle one): AFDC Disability Full-Time Employment Part-Time Employment Retirement SSI Full-Time Student Part-Time Student Unemployed

Others in household being served: _____

How did you find out about my services? _____

Will you be filing these services with your health insurance company? _____ Yes _____ No

Name and phone number of your medical doctor:

_____

Person to contact in case of an emergency:

Name: _____ Phone number: _____ Relationship: _____

# Dori C. Luke, MSW, LCSW, SEP, BASE
## *Pre-Counseling Assessment Information*

Name: _____ Date: _____

Please tell me why you are here today:

Have you ever had any type of counseling before? _____ Yes _____ No

If yes, please check:

_____Individual Counseling _____Couples Counseling _____Family Counseling
_____Group Counseling _____In-patient Treatment _____Substance Abuse Help
_____Support Group, type _____

If yes, when was your counseling, who was your therapist, and how long did it last?

Please list any prescription medications or herbal supplements you are taking:

Please list who and what is supportive and/or helpful in your life:

Check any significant changes over the last three years:

_____ Deaths _____ Job Loss _____ Relocation
_____ Births _____ Promotion _____ Injuries
_____ Illnesses _____ Marital Status _____ Other

Please explain any of the above:

Please check any issues that are of concern to you:

_____ Relationship issues
_____ Depression
_____ Anxiety
_____ Self-Esteem issues
_____ Social Life
_____ Suicidal Thoughts
_____ Self Harm
_____ Eating
_____ Alcohol/Drug Use
_____ Work / School
_____ Sexual Concerns
_____ Spiritual Life
_____ Finances
_____ Legal Involvement
_____ Other (please specify) _____

Is there any history of alcohol/drug abuse in your life and/or your family?
_____ yes _____ no

Is there a history of physical, sexual, or emotional abuse in your life, and/or your family?
_____ yes _____ no

**This information will be held in the strictest confidence.**

# Dori C. Luke, MSW, LCSW, SEP, BASE
## *Counseling Agreement*

***Welcome! I look forward to working with you in helping you achieve the goals which motivated you to find me. The following agreement and guidelines have been established to facilitate our work together (please feel free to comment or ask any questions):***

I hereby grant my permission for any counseling, testing, or diagnostic evaluation that may be needed in counseling. The counseling sessions and records are **strictly confidential** except where state law requires the reporting of threats of violence, harm to self or others, or child abuse and neglect (from evidence or suspicion), when the courts subpoena information, and when information is needed for billing. If your insurance company is paying in part or full for your session, they sometimes have the right to gain information regarding your counseling sessions. This varies with different insurance companies. If there is any question about this, it is suggested you contact your insurance company so you know what access they are allowed to have as part of your policy agreement. Additionally, in order to file through insurance, it is required that I give you a diagnosis. It is important that you understand that not all diagnoses are covered under any given insurance plan and that when a diagnosis is given it becomes part of your records with the insurance company.

It is also important that you understand our relationship is kept strictly professional. My relationship with you as your therapist prevents me from maintaining any kind of social relationship with you. If I should see you in public, I will respect this confidentiality and not indicate that I know you. Unless you approach me, I am unable to acknowledge you as someone I know as a client.

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards set forth by the National Association for Social Workers. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results. Your sessions are your time to discuss any topics which you feel appropriate. You may end our counseling relationship at any time. Although, I do ask that you participate in a closure/termination session. You also have the right to refuse or negotiate modifications of any of my suggestions that you believe may be harmful. At any time, either you or I may initiate discussion of possible positive or negative effects of entering or not entering counseling, continuing or not continuing counseling, and/or using or not using certain techniques. It is not unusual that as the counseling process progresses you may feel as though things at times are getting worse before they get better.

If at any time for any reason you are dissatisfied with my services, please let me know. Should you and/or I believe that a referral is needed, I will provide you with some possible referral sources. A verbal exploration of alternatives to counseling will also be made available upon your request. If you have a complaint which you believe needs to be registered with my governing board you can contact the North Carolina Board of Social Workers referencing my license number: C004450.

Being aware that there may be potential for emotional strains, stresses, and life changes as a result of counseling, by signing below you agree to enter the counseling process. And understand that Dori Luke does not guarantee any particular results or outcomes from the counseling process.

**Fees:** The standard fee for sessions is $150.00. Session length is typically 53-60 minutes. For individuals using insurance you will have a co-pay or deductible amount determined by the insurance company. By signing below, you accept financial responsibility for charges incurred during the course of therapy. The fee and payment policies have been discussed, and a fee of $_____ (default $150.00) per session has been set. If we have made arrangements that I file insurance directly, then you are responsible for any co-pays due and are responsible for payment in full if your insurance company does not pay for any reason.

**Payments:** I request that you bring your payment at the time of the appointment. I accept cash, checks, or credit cards (they carry a 3% transaction fee) -- because of this 3% credit card fee. many have been sending payment via Zelle or Venmo, which I accept. If you are paying by Zelle or Venmo, kindly send payment either directly before or after the session or if you are paying by check, please have your check filled out prior to or at

the beginning of the session. Bounced or returned checks will carry a charge of $20.00 per check. Full payment will be required within 48 hours of your notification of a bounced check.

**Cancellations: A 24-hour notice is required for all cancellations**. Because I have to absorb the missed income and costs for missed appointments and cancellations within a 24-hour period, there is a full charge for the missed appointment if appointments are missed or called to be cancelled within 24 hours of the appointment. If you have an insurance co-pay, you will not be allowed to pay your co-pay for the missed appointment, the full $150.00 will be charged, as insurance companies do not reimburse for charges resulting from missed appointments. Please note, should you not be able to attend in person due to circumstances, you have the option of a phone or Facetime appointment by calling or texting in advance to arrange such. All cancellations or requests for phone appointments can be made by calling or texting me at 704-576-3635.

**Use of Phone, Text and Email Communication:** Clients are advised that these forms of communication are not fully secure and there may be risk involved when using these forms of communication to share clinical information. It is strongly advised that clients share clinical information in personal sessions and not thru phone, email, and text communications. I will use brief phone or text contact to communicate with you outside of sessions, primarily for scheduling purposes or to ascertain needs. Please note that I will do my best to return calls, texts, and emails within 24 hours during normal business hours. Calls, texts and emails received after 12/noon on Fridays will be returned the following Monday, unless otherwise noted in my outgoing voicemail message.

**Emergency Service:** Please note Dori Luke does not offer an emergency service. In the event of an emergency, you are instructed to call the Mental Health Call Center at 704-444-2400, go to your nearest emergency room, or call 911 to receive immediate assistance.

**Termination of Therapy:** Termination or closure of therapy can be a healthy part of the healing process to celebrate progress made and to share feelings regarding ending the therapeutic relationship. Because I respect an individual's decision to terminate therapy at any time, I encourage and appreciate open communication regarding this issue with clients. Although extremely rare, it may become necessary for me to terminate with a client, particularly if the therapeutic relationship becomes compromised (e.g. client becomes verbally abusive with therapist or disregards therapist's boundaries or regular agreed upon payment for services is not being made). Clients will be informed of the concerns and, in my discretion, may be given the opportunity to amend behavior, if appropriate, or a termination process will ensue.

***Lastly, I am truly grateful to be able to provide my services to you and/or your children. My practice is based on a work-ethic centered on giving my best service to all. Thank you for respecting these policy guidelines and updates. If you would like to discuss any of the above, please do so before signing.***
***Warmly, Dori Luke, MSW, LCSW, SEP, BASE***

**Client or Representative:**
I have read the above policy and agree to comply with the terms and conditions above:

_____ _____
Client Date

_____ _____
Client Date

_____ _____
Dori C. Luke, MSW, LCSW, SEP Date

# Dori C. Luke, MSW, LCSW, SEP, BASE
## *HIPPA Consent Form*

CONSENT FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

By signing below, I hereby voluntarily and knowingly consent to allow Dori C. Luke, MSW, LCSW, SEP to use and/or disclose my health information as deemed appropriate to carry out treatment, payment, and/or healthcare operations of the practice. For substance abuse information, payment information can only be obtained by those for whom an authorization exists.

**I have received a copy of the Notice of Privacy Practices (also available on website).**

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Witness signature Date

If you are the legal representative of the person listed above, please check off the basis for your authority:

☐Parent of Minor
☐Power of Attorney (attach copy)
☐Guardianship Order (attach copy)
☐Other:_____

Client Name:_____ Date of Birth:_____

Home Address:_____
Street City State Zip

**Dori C. Luke, MSW, LCSW, SEP, BASE**
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