Marley J Wolfe Counseling Services
6 West Pointe Blvd
Mauldin S.C. 29662
864-360-4287

Directions from I-385

Take ***I -385*** South away from the town of Greenville

Take Exit ***34*** Butler Road – Turn right onto *Butler Road*

Cross the main intersection in Mauldin (276 or Main Street)

Pass *Ingles* on the right

Pass the *State Farm* sign on the right.

Turn right on ***West Pointe Blvd*** (if you pass the *Bank of America* you have gone too far)

My office is on the right at ***6 West Pointe Blvd*** (White and Black sign above office)

Call if you have questions or need assistance don't hesitate to call.

Directions from I-85

Take I-85 and then take the ***Mauldin Road Exit***. *Main Street* (or also known as Laurens Road)

Enter the town of Mauldin until you come to the intersections of Main Street and Butler Road. Turn right onto Butler Road at the *Walgreens.*

Pass *Ingles* on the right

Pass the *State Farm* sign on the right.

Marley J.Wolfe M.Ed.LPC Counseling Services

Statement of Professional Disclosure and Consent for Psychotherapy

Clients Rights:
You are entitled to receive information informing you of your therapist credentials and experience.
You should know that in a professional psychotherapy relationship, sexual intimacy is never appropriate, is illegal in S.C. and should be reported to the Grievance Board (803-896-4658)
The information provided by you during psychotherapy sessions is legally confidential in the case of psychotherapist. However, there are some possible exceptions to that confidentiality.

1. If you reveal that you intend to harm yourself or someone else, it is required by law that the authorities and the intended victims be notified.
2. If you reveal information about current or on-going child/elder abuse or neglect, that information must be reported.
3. If your psychotherapy charts, including sessions notes, diagnoses, client information form, etc. is subpoenaed by a Family or Criminal court of law.
4. In the event of true crisis and emergency see the Contract for Safety section in this paper work and follow the steps to accommodate your needs. Additional services will require additional payment for on call emergency services. If your psychotherapist cannot meet your needs for this any other reason, your psychotherapist will make every effort to make an appropriate referral.
5. Individual sessions are usually scheduled 50minutes one time per week.
6. Fees are payable on the day that services are delivered and are established during your first session.
7. I understand that I will be billed for any no show appointments and must give 24 hours notice to avoid a fee.

My signature below confirms that I understand and accept all the information in this document.

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

I hereby acknowledge that I have received or have been given an opportunity to read a copy of Marley Wolfe's ***Notice of Privacy Practices*** at the end of this document. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Marley Wolfe. I also ***consent for treatment*** and understand and agree to the statements above.

Signature of Patient/ Client_____ date_____

_____ date_____

Signature of Parent, Guardian or Personal Representative

Contract for Safety

One of the goals of your therapy with Marley Wolfe M.Ed LPC is to enable you to live a long and productive life as free from pain and as many displeasures as possible. In the event that I become a danger to self and /or others I agree to contact a family member and or friend to help me work through the crisis and practice constructive alternatives to self harm that I have learned from my therapist. I agree to contact the office of Behavioral Health services at 864-271-8888. If that doesn't help I agree to notify the clinical assessment office of Behavioral health services at 864-455-8988. If I am still faced with a life threatening emergency, then I agree to call my physician or psychiatrist, and call 911 and proceed to the closest emergency room.

_____ _____
Client signature date

_____ _____
Witness signature date

REQUEST FOR ALTERNATIVE COMMUNICATION CHANNELS

Please telephone me ONLY at this number _____
Please direct all postal mail to this address _____
_____

You may e-mail me at this address _____
Signature of client _____date_____

FINANCIAL POLICY

Your insurance policy is a contract between you, your employer and the insurance company. It is the clients responsibility to check his/her policy or contact the insurance company to know how a specific plan covers psychotherapy services. If you are planning to file for reimbursement from your insurance company, please notify a counselor or the office assistant.

The standard fee for individual , couple or family sessions is 90.00. Any adjustments to this fee amount must be arranged with the counselor. There is a sliding scale where fees are determined by annual income range and persons in household. If you use insurance the contracted amount is what you will be billed. If you have arrangements with a church and prior authorization has been made please discuss this with you counselor.

Unless cancelled 24 hours in advance you may be charged for missed appointments at the rate of a normal visit.

Clients Signature _____ Date_____
Counselor's name_____ Date_____
Fee Amount _____ Date_____

Disability Application forms

There will be a 25.00 application fee for any Met Life applications and updates for progress Required for an employees short term disability .

RELEASE FOR THE EVALUATION AND TREATMENT OF A MINOR

As parent or legal guardian of _____
I authorize his/her evaluation and treatment. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

Signature_____Date_____
Witness _____Date_____

Marley Wolfe LPC M.Ed
Mauldin **S.C 29662**

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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, appointment reminder notices and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Fold

Fold

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500
#30148 — Medical Arts Press

Use with Envelope #14145 (gummed) or #14146 (self seal)

Mfd. by Medical Arts Press
Call toll-free 1-800-328-2179

Social History for Marley J Wolfe , M.Ed.LPC

Name _____
Date_____
I like to be called "_____" Birth date_____ Age ____
Presenting Problem: Chief complaint? What brings you in for treatment?

_____
_____
_____
_____

Other Problems (check those that apply)

___Sad	___Withdrawn	___Low Self-esteem
___Lonely	___Low energy	___Unable to have fun
___Guilty	___Hopeless	___Difficulty making decisions
___Grief	___Feel worthless	___Thoughts of killing self
___Loss of faith	___Extreme fatigue	___Isolative

___Appetite change in the past month.
Describe:_____
___Sleep problems.
Describe:_____
___Sexual problems.
Describe:_____
___Eating problems.
Describe:_____

___Restless	___Overactive	___Can't concentrate
___Talking too much	___Distractible	___Interrupt frequently
___Easily bored	___Can't be still	___Act before thinking
___Can't follow directions	___Can't remember	___Clumsy

Feeling increased anxiety in the past month.
Describe:_____

___Argumentative	___Irritable	___Easily angered
___Panic attacks	___Pounding heart	___Rapid breathing
___Feeling out of breath	___Chest pain	___Sweating
___Hot/cold flashes	___Light headed/dizzy	___Nausea
___Trembling	___Choking sensation	___Tingling hands or feet
___Feel you're going crazy	___Fear heart attack	___Fear of certain places
___Fear new things/places	___Very shy	___Embarrass easily
___Fear speaking in public	___Uncomfortable in groups	___Think others are better than you

Any other fears of animals, blood, disease, driving, flying, heights, tests, etc… Describe:

_____

_____

_____

Any of the following:

___Nightmares ___Flashbacks ___Blackouts

___Periods of unaccounted time ___Hallucinations (auditory, visual, olfactory, gustatory)

___Fear of being hurt, followed or watched

Any of the following:

___Count objects ___Wash hands frequently ___Clean excessively

___Insist in order ___Worry about germs/contamination ___Hoard things

___Have special numbers perfection ___Check locks, windows, ovens, etc. ___Insist on

___Start but don't finish ___Take long time to bathe, dress, shave ___Mood swings

___Feel little need to sleep ___Feel extremely happy ___Racing thoughts

___Talk rapidly ___Do things to excess

Current medications including over-the-counter:

_____

_____

Medically related hospitalizations:

_____

_____

Past illnesses and injuries:

_____

_____

Any blows to the head, falls, loss of consciousness or fainting? Describe with dates:

_____

_____

_____

Allergies:_____

History of drugs or alcohol?

_____

Number of Alcoholic drinks per day _____ per week _____

Number of cups of coffee per day _____ Number of glasses of tea_____ Number of sodas_____

Individual Cigarettes per day _____ or Packs of cigarettes per day_____
Marijuana/ other drugs _____

_____

Are you now or ever been Homicidal?

_____ Are

Are you now or have you ever been Suicidal?

_____

Access to means? (a way to carry out thoughts of hurting self or others)_____

_____

History of Violence:

_____

Explain:_____

_____

Any history of mental illness (anxiety, bipolar disorder or manic depression, depression, schizophrenia) in the family? Include grandparents, aunts, uncles, brothers and sisters. If so, what illness and what relationship?

_____

_____

_____

Any history of physical, emotional or sexual abuse? If so, explain:

_____

_____

_____

_____

Any history of addictions in the family? (alcohol, drugs, gambling, sex, Internet, etc…) If so, what addiction and what relative?

_____

_____

_____

_____

_____

_____

_____

_____

Relationship History:

List all of the people living in the home:

Name	Age	Relationship

Are you currently married or involved in a relationship? _____

How many times have you been married? _____

Current relationship/marriage _____ How long? _____

Describe the relationship:

_____

_____

_____

_____

Children ? ____

Son's names and ages:

_____

Daughter's names and ages:

_____

Previous relationship/marriage ____ How long? _____ Describe the relationship:_____

_____

_____

_____

Children ? ____

Son's names and ages: _____

Daughter's names and ages: _____

Educational/Military/Job History:

Did you graduate high school? If so, where?

_____

_____

Do you have any additional educational classes, certificates or degrees? If so, what and from where?

Military Service: yes or no Branch_____ Years of Service_____

Psychosocial Needs/Patient support systems including spiritual/hobbies/legal/financial:

Are you currently involved in any support groups? If so, which ones?

Are you involved in spiritual activities (church, synagogue, etc…)? If so, where?

What are your hobbies?

Have you been involved with the legal system in any way? If so, explain?