Graciela Aires Rust MS, LPCA, CRC
(808) 824-0721 E-mail: info@holisticgrowth.net
www.holisticgrowth.net

HOLISTIC GROWTH
Integrative Mental Health Counseling –Multicultural Consulting
Complementary and Alternative Therapies – Life Coaching

CLIENT'S REGISTRATION FORM

Date:_____ **DX (office only):** _____

Last Name_____ First _____MI_____
Nickname _____ Sex: M F SS# _____ DOB _____Age_____
Street _____ City_____ State _____
Zip_____ Home_____ Cell # _____
Work # _____ Email _____
Marital Status: Married _____ Single _____ Separated _____Divorced _____Widowed _____
Medications:_____
_____

Primary Care Physician's Name _____ Phone _____

Work: ___Full time ___ Part Time Company: _____ Occupation: _____

Student: ___ Full time ___ Part-time Name of the school: _____

Grade: _____

Client's Full Name _____ Date _____

Client's Signature _____ Date _____

If the client is a minor:

Father's Full name _____
Father's Signature _____ Date_____
Mother's Full name_____
Mother's Signature _____ Date _____

Therapist's Initials _____ Date _____ Client's Initials _____ Date _____

STATEMENT OF CLIENTS' RIGHTS

I provide psychotherapy, counseling, life coaching, complementary and alternative therapies, and multicultural consulting to all clients without regard to race, color, religion, national origin, sexual orientation, age, disability, veteran status, or any other discriminatory factor recognized by law. When you receive services from me, you also have certain rights, which I have listed below.

Right to Confidentiality

Unless the law requires it, your records and other information about you will not be released without your written permission (or if you are a minor, the written permission of your parent or legal guardian). There are, however, some circumstances under which I may be required by law to share information with others about the services you receive, to include:

-If you give written permission I may share information with any person or agency you identify.

-If I believe that you are in imminent danger to yourself or to others, or if I believe you are likely to commit a crime, I may share information with law enforcement and with threatened individuals.

-To report a crime committed by you on my office premises or against me.
-The court may order me to release your records without your permission.
-If I suspect that you have neglected or abused a child or dependent adult, or you are being investigated for child abuse or neglect, I am required by law to share information with the county protective service officials

-If you are HIV positive and I am aware that you are not following proper control measures, I am required to report this to agents charged with the protection of public health.

-To medical personnel in a medical emergency.
-Your insurance carrier will also know your diagnosis and information related to process claims.

Right to Refuse Treatment

You have the right to consent to treatment or services and may withdraw your consent at any time. If you refuse a recommended service or treatment, I will attempt to inform you of the consequences for such refusal. The only time that you can be treated without your consent is in an emergency situation, when it has been court-ordered, or if you are a minor and your parent or guardian has given consent.

Right to Know the Cost of Services

You should be informed of the costs of your services before the provision of the services. It is your responsibility to arrange for payment of costs, and your services can be terminated for failure to pay for agreed costs.

Right to Privacy

You have the right to be free from any unwarranted search of your person or property.

Right to be Treated with Dignity

I do not administer any potentially painful procedures or stimuli to reduce the frequency or intensity of a behavior.
I must protect clients from harm and report any form of abuse, neglect, or exploitation.

Your Information.

Your Rights
Our Responsibilities.

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.**

Your Rights

You have the right to:

-Get a copy of your paper or electronic medical record
-Correct your paper or electronic medical record
-Request confidential communication
-Ask us to limit the information we share
-Get a list of those with whom we've shared your information
-Get a copy of this privacy notice
-Choose someone to act for you
-File a complaint if you believe your privacy rights have been violated

>- *See page 2 for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

-Tell family and friends about your condition
-Provide disaster relief
-Include you in a hospital directory
-Provide mental health care
-Market our services and sell your information
-Raise funds

>- *See page 3 for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

-Treat you
-Run our organization
-Bill for your services
-Help with public health and safety issues
-Do research
-Comply with the law
-Respond to organ and tissue donation requests
-Work with a medical examiner or funeral director
-Address workers' compensation, law enforcement, and other government requests
-Respond to lawsuits and legal actions

>- *See pages 3 and 4 for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	-You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. -We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	-You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. -We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	-You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. -We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	-You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. -If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	-You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. -We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable cost-based fee if you ask for another one within 12 month.
Get a copy of this privacy notice	- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. -We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	-You can complain if you feel we have violated your rights by contacting us using the I information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights by Sending a letter to 2000 Independence Avenue, SW – Washington D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	-Share information with your family, close friends, or others involved in your care -Share information in a disaster relief situation -Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	-Marketing purposes -Sale of your information -Most sharing of psychotherapy notes
In the case of fundraising:	-We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	- We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	- We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	-We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	-We can share health information about you for certain situations such as: -Preventing disease -Helping with product recalls -Reporting adverse reactions to medication -Reporting suspected abuse, neglect, or domestic violence -Preventing or reducing a serious threat to anyone's health or safety
Do research	-We can use or share your information for health research.
Comply with the law	-We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	-We can share health information about you with organ procurement organizations.
Work with a medical examiner orfuneral director	-We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	-We can use or share health information about you: -For workers' compensation claims -For law enforcement purposes or with a law enforcement official -With health oversight agencies for activities authorized by law -For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	-We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Holistic Growth, Graciela Aires Rust MS, LPCA, CRC

Therapist's Initials _____ Date _____ Client's Initials _____ Date _____

OFFICE POLICIES

Welcome to Therapy! My goal in therapy is to help clients get unstuck, move forward and obtain symptom relief of anxiety, depression, or any other mental health challenge. Our work together depends on developing an open and honest relationship that will allow you to become aware of old patterns and beliefs that affect the quality of your life.

Session Length

I offer 60 sessions and 90 minute for intake sessions ($ 95 for 60 and $ 150 for 90). When you make an appointment the time is reserved especially for you. If you are late to your appointment the sessions must still end at the scheduled ending time. In the beginning sessions, I will help you establish goals for our work together. My goal is to bring about changes in your life in the briefest amount of time possible.

Fees and Payments and Insurances

The fee for a comprehensive clinical assessment is $ 150 and the fee for Individual psychotherapy is $ 95 per session. Payment in full is expected at the end of each session. We now accept Blue Cross Blue Shield as in-network provider for psychotherapy sessions. Holistic Growth accepts all other insurance plans as an out–of-network provider. Services may be covered in full or in part by your health insurance or employee benefit plan. You can also choose to pay either through check, cash or credit card. Fees for additional time or services will be pro-rated on the sixty minute session fee, for example, consultation with other professionals or preparation of reports or correspondence.

Cancellation Policy: If you fail to come for your appointment or give less than 48 hours cancellation notice you will be held responsible for the payment of the session. Cancelling with 48 allows me to offer a client your appointment time and also if other clients cancel on time then I can offer you a broader array of appointment times.

Limits of Confidentiality

As your therapist my goal is to establish a safe place for you to openly explore your personal issues. I am committed to guarding your right to privacy, within the limits of the law. There are certain situations in which a therapist is required, by law, to reveal information obtained during therapy. Disclosure is required by law in the following circumstances:

1. If there is a known risk of homicide or suicide this must be reported to the appropriate authorities.
2. If there is a current or past child abuse or a reasonable suspicion of abuse/neglect of a child or vulnerable adult, this must be reported to the appropriate authorities.
3. When a court of law issues a legitimate court order signed by a judge.

Release of Information: Except in the above circumstances, I will only release information about you if you sign a release of information.

Termination: When you decide to leave therapy, please give me at least 2 weeks' notice. This will make it possible for us to review your accomplishments and understand how to keep moving forward.

My Contact Information

Phone Numbers is 808- 8824 – 0721. I will return calls during the week in a timely manner. I will return weekend calls on Monday (unless it's a holiday)

I have read the above policies and I understand and agree to them. My signature below affirms my informed and voluntary consent to enter therapy (and/or have my children enter therapy):

Client's Name _____ Date_____

Client's Signature _____ Date _____

GRACIELA AIRES RUST MS, LPCA, CRC
Professional Disclosure Statement

I am pleased to be working with you as your counselor. This information is intended to inform you about my background, to describe certain issues regarding our therapeutic relationship, and to ensure that you have been informed of your rights and responsibilities within our counseling relationship. Please read it carefully and feel free to ask any questions you may have.

Qualifications/Experience

I hold a Master of Science in Rehabilitation Counseling and Psychology from The University of North Carolina at Chapel Hill, School of Medicine. I graduated with dual tracks in Psychiatric Disabilities and Developmental Disabilities. I am a Certified Rehabilitation Counselor (CRC # 00117680), a Licensed Professional Counselor Associate in North Carolina (LPCA #A10364), Alternative Medicine Practitioner, Integrative Wellness and Life Coach, Certified Yoga Instructor, and Multicultural Consultant. I began my work in the field of counseling and mental health during my graduate practicum experience in August, 2012 and my education and training have prepared me to counsel adults, children, adolescents, families and groups.

Description of clientele served and Description of services offered

I have experience working with adolescents and adults with developmental and psychiatric conditions in individual, group, couples, inpatients and outpatients settings offering services in English and Spanish. I provide person centered treatments, integrating Eastern mindfulness and alternative treatments with western evidence based psychology. My therapeutic approach is to deliver support and practical feedback to help clients effectively address personal life challenges and to make positive changes. I have extensive training and experience in working with individuals and families facing distress in issues related to depression, anxiety, acculturation stress, anger issues, codependency, complex trauma, eating disorders, grief and loss, life stage related issues, life transition, personal relationships, post-traumatic stress disorder, pregnancy, prenatal, postpartum, racial, ethnic and cultural identity, self-esteem, spirituality, trauma and abuse, and to those in need for integrative wellness, as well as for interpersonal effectiveness. I work with empathy and understanding with each individual, group or family to overcome challenges and help them build on their strengths and reach the personal growth they are committed to achieving in a holistic manner.

Nature of Counseling

Therapy provides the opportunity for healing, growth, self-discovery and insight in the context of a safe, supportive environment in which every person seek counseling for individual reasons. For this reason, there is no one approach that may work best for everyone. In therapy, we work together to identify and work on any issues you bring to our session. From a person centered perspective, I follow theoretical approaches that best fit the client's particular situation according to evidence based practices in counseling with the desire to promote healing in the whole person: emotional, spiritual, cognitive, and relational. The models I utilize involve Acceptance and Commitment Therapy, Alternative Therapies , Attachment Based Therapy,

Behavioral, Cognitive Behavioral Therapy , Cognitive Behavioral Complex Trauma , Developmental, Existential, Family Therapy, Family System, Gestalt Therapy, Humanistic Therapy, Integrative, Interpersonal, Life Coaching, Mindfulness-based, Motivational Interviewing, Multicultural Sensitive Approaches, Person-Centered, Play Therapy, Rational Emotive, Reality Therapy, Relational, Solution Focused Brief (SFBT), Spiritual Healing, Trauma Focused.

Counseling includes your active involvement as well as efforts to change your thoughts, feelings and behaviors. Sometimes, I may request that you do "homework" with the purpose of obtaining further reinforcement to concepts discussed in session, or to promote further insight. It is important that you are aware in advance the risk and benefits of counseling. Often in therapy, as we discuss unpleasant aspects of your life or situation, you may experience uncomfortable feelings like sadness, guilt, anger, or frustration. On the other hand, psychotherapy has also been demonstrated to provide benefits such as better relationships, solutions to specific problems, significant reductions in feelings of distress, and an overall improved well-being. In regard to outcomes, and given the nature of psychotherapy, it is difficult to predict with precise certainty result, or to determine a clear estimate of time needed in order for the client to attain his or her personal goal. 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 for you Essential factors for success in therapy include the motivation level of the client to be receptive to the process of change, being consistent with attending sessions, and working towards his or her goals outside of sessions.

The Counseling Relationship:

During the time that we work together we will meet weekly, or as scheduled, in 50 minute sessions. Our time spent together may be emotionally intimate, it is important to understand that our relationship is professional, not social. Our contact will be limited to the counseling sessions we arrange, except in the rare case of an emergency. I do not discriminate on the basis of age, race, ethnicity, gender, religion, national origin, sexual orientation or differences in physical abilities.

Client Rights:

You are in control of your counseling experience and are free to end our relationship at any time. If you decide to end your counseling sessions I ask that you discuss this decision with me personally. I am available to discuss the positive and negative effects of beginning, continuing or ending the counseling process.

My counseling practice is guided by the American Counseling Association code of ethics. A detailed overview of the American Counseling Association's code of ethics can be found at this website: (http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx)

If you feel that I have violated the above code of ethics you have the right to report your complaint to the following organization:

North Carolina Board of Licensed Professional Counselors

PO Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007.
Email: LPCinfo@ncblpc.org
Fax 336-217-9450

As a psychotherapist with a provisional license, I work under the supervision of Dr. Candice Mowrey who you can also contact for questions regarding my practice; her telephone number is 919-345-2132.

Referrals:

If you or I feel that a referral to a more appropriate professional is needed, I may be able to provide you with contact information for alternative programs and/or professionals that may be more able to assist you. We can discuss these possibilities together, but you will be responsible for contacting and evaluating your options.

Confidentiality, Responsibilities and Exceptions

The therapist-client relationship is confidential. "Confidential" means that, with certain exceptions, I will disclose neither the fact that we have a professional relationship nor the content of our sessions without your explicit written authorization. Discussions between you and me, and even the fact that you are in therapy with me, are confidential. Having confidentiality and trust is essential to your therapeutic experience and therapeutic outcome. However, exceptions to confidentiality do exist. These exceptions include, but are not limited to, the following situations:

I. If I determine that you may be in danger to yourself or others.
II. If you provide information that leads me to believe that a child (under 18 years of age), elderly person, or disabled adult is or has been abused or neglected.
III. A court order has been issued to release information about you and your clinical record.
IV. If you request in writing that I may release information about you.
V. Your insurance carrier will also know your diagnosis and information related to process claims.

It is also important for you to know that if I see you in public, I will protect your confidentiality by greeting you only if you greet me first. If at any time you have any questions regarding confidentiality, you should bring them to my attention.

Medical Records and Diagnosis:

Federal and state laws require that personal medical information be maintained in a safe and confidential way. All of our communication becomes part of the clinical record, which is accessible to you upon request. If you

require a copy of all or part of your medical record, please make an appointment with me to review the information needed and to discuss the best way to provide you with that information.

Some health insurance companies will reimburse for counseling services and some will not. Most health insurance companies require a diagnosis of a mental-health condition and indicate that you must have diagnosable "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Length of sessions

My services will be rendered in a professional manner consistent with accepted ethical standards. If you are unable to keep an appointment, please call the office to cancel or reschedule at least 48 hours in advance. If I do not receive such advance notice, you will be responsible for paying for the session that you missed. Please arrive 10 - 15 minutes prior to your appointment time to give yourself time to get ready for the session.

Fees and Payments and Insurances

The fee for a comprehensive clinical assessment is $ 150, the fee for individual psychotherapy is $ 95 per session, and group counseling $ 45. Payment in full is expected at the end of each session. I accept Blue Cross Blue Shield for psychotherapy sessions as in-network provider. I accept all other insurance plans as an out–of-network provider. Services may be covered in full or in part by your health insurance or employee benefit plan. You can also choose to pay either through check, cash or credit card. Fees for additional time or services will be pro-rated on the sixty minute session fee, for example, consultation with other professionals or preparation of reports or correspondence.

Emergency/Crisis

I do not provide emergency or crisis services. If you experience a mental health emergency, please go to the nearest hospital Emergency Room, or call 9-1-1, or you may call Wake County Human Services Emergency line at 919-250-3133 or Holly Hill Respond line at 919-250-7000.

My Contact Information

Due to the nature of my work, I am often not available by phone as I do not respond calls when I am with a client. My telephone is answered by a voicemail that I listen regularly. You may call my voicemail at any time at (808) 824 – 0721 and please let me know when you can be reach. I will make every effort to return your call within 24 hours with the exception of weekends and holidays. If you. When, calling please provide a number I can call back and leave a message. If I have to leave a message, I will say my name and to return my call. I will not identify myself with as therapist.

Consent to Treatment

By your signature below, you are indicating 1) that you voluntarily agree to receive mental health assessment and mental health care, treatment, or services, and that you authorize me to provide such assessment and care, treatment, or services as I consider necessary and advisable; 2) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such care, treatment, or services that you receive through me; 3) that you have read and understood this statement and have had the opportunity to ask questions about, and seek clarification of, anything unclear to you.

This disclosure statement is intended to provide you with the information needed to gain your consent to begin counseling services. You always have the right to consent to treatment, and likewise, you have the right to withdraw that consent at any time. By signing below, you are acknowledging that you have read and understood this document and agree with the conditions outlined.

_____ _____ _____

Client Name (Print) ***Client Signature*** ***Date***

_____ _____ _____

Parent/Guardian Name (if minor) ***Parent/Guardian Signature***
Date

Graciela Aires Rust, MS, LPCA, CRC

_____ _____

Counselor Signature ***Date***