

ASCEND PSYCHOLOGICAL SERVICES, PLLC

Rockwell, NC 28138

Demographic Form

Date \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Preferred Name:** \_\_\_\_\_ **Gender -** *Male* *Female* **Marital Status** Married Single Other

Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/Guardian legal custody papers \_\_\_YES\_\_\_ NO Office will need to make copy of for children under age 18- **BRING TO OFFICE**

Mailing Address \_\_\_\_\_ Phone – Home # \_\_\_\_\_

City, State Zip Code \_\_\_\_\_ Mobile # \_\_\_\_\_

Email Address: \_\_\_\_\_

Do you want to receive email and/or text for appointment reminders? YES NO *EMAIL* *TEXT*

Employer \_\_\_\_\_ Work # \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Insurance Policy # \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Insurance phone # \_\_\_\_\_

Name and Contact Information of referring physician (if any): \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

Psychiatric History: \_\_\_\_\_

Medical History: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

## ASCEND PSYCHOLOGICAL SERVICES, PLLC

110 A East Main Street  
P. O. Box 271  
Rockwell, NC 28138  
Ph: Office - 704-279-0626  
Fax: 704-279-0344

### Client Rights

- The Confidential handling of records
- Participation in the development of client's treatment plan
- Having an Individualized, written treatment plan within 30 days of admission to Ascend Psychological Services, PLLC
- Having all civil rights, including the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, register and vote, bring civil actions, and marry and get a divorce, unless the exercise of a civil right has been precluded by an unrevoked adjudication of incompetency
- To dignity, humane care, and freedom from mental and physical abuse, neglect, and exploitation
- To treatment, including access to medical care and habilitation, regardless of age or degree of mh/dd/sa disability. To receive necessary treatment for prevention of physical ailments.
- To live as normally as possible while receiving care and treatment and receive age-appropriate treatment for diagnosis. To have opportunities that enable the individual to mature physically, emotional, intellectually, socially, and vocationally to include special education and training in accordance with state and federal law
- To be free for unnecessary medications and for medication not to be used for punishment, discipline, or staff convenience
- Notification that release / disclosure of information may only occur with an authorization or consent unless it is an emergency or for other exceptions as detailed in G.S. or 164.512 of HIPPA
- Right to only release minimum information necessary for coordination of care and services
- Access to a clinician in the case of emergency
- Effective communication while receiving care, treatment, and services, including any complaints about patient care
- The right to consent to or to refuse treatment
- The right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD) to protect and advocate for my rights:

Phone: 919-856-2195 or 877-235-4210

Email: [info@disabilityrightsncc.org](mailto:info@disabilityrightsncc.org)

Mail: Disability Rights, 3724 Nation Drive, Suite 100, Raleigh, NC 27612

Fax: 919-856-2244

**My signature below verifies that I have read and understand my Client Rights.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Ascend Psychological Services, PLLC**  
**Professional Disclosure Statement**  
**Alexandra Tuck, MSW, LCSW**  
**Office 704-279-0626**  
**Fax 704-279-0344**  
**E-mail: [atuck@ascendpsv.com](mailto:atuck@ascendpsv.com)**

**Qualifications**

I received my Master's of Social Work in 2014, from UNC Charlotte. I also received a Bachelors Degree in Psychology in 2009, from Quinnipiac University. I have been working in the mental health field since 2009. I am currently licensed as a Licensed Clinical Social Worker in the state of North Carolina (#C 010330).

**Counseling Background**

My counseling background consists of experience working with both children, adolescents, and adults in both individual, group, and family settings. I have worked with children, adolescents, and adults in the home, community, school, case management, and in-home therapeutic services. Areas of treatment include behavioral, personal, relational, emotional, and familial problems.

My theoretical approach varies depending on the needs of the individual, usually taking on an Eclectic approach, but my orientation is mostly Cognitive Behavior Therapy and Solution Focused Brief Therapy. I also have experience in Person Centered and Existential Therapy. I have also been trained in Trauma informed Therapy.

**Session Fees and Length of Service**

Counseling sessions will typically last 45-60 minutes unless there are other extenuating circumstances which require more time. The fee for an intake session is \$ \_\_\_\_\_. The fee for a standard session is \$ \_\_\_\_\_. There is a sliding scale for those with financial hardships. If applicable, insurance will be filed for you, but you are responsible for any co-pays or deductibles. Payment is required and expected at the time of services in the form of cash or checks. Failure to submit payment will result in termination of counseling relationship initiated by you and upheld by myself unless otherwise stated and agreed upon with counselor.

**Use of Diagnosis**

Please note that some health insurance companies will reimburse for counseling services and some will not. In addition, most will require a diagnosis of a mental health condition and indicate that you must have an "illness" before they will agree to reimburse you or pay for services. 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 and client file.

**Confidentiality**

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others, including child or elder abuse, or (c) I am ordered by a court to disclose information.

If seen in public, I will protect your confidentiality only by acknowledging you if you approach me first.

**Complaints**

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization listed below should you feel I am in violation of these codes of ethics. I abide by the ACA Code of Ethic <http://www.counseling.org/Resources/CodeofEthics/TP/Home/CT2.aspx>. Please submit all complaints to

**North Carolina Association of Social Work Boards**

**Main office**

**400 Southridge Parkway, Suite B**

**Culpeper, VA 22701**

**Phone: 800.225.6880/540.829.6880**

**Fax: 540.829.0562**

**Email: [info@aswb.org](mailto:info@aswb.org)**

Complaints related to concerns with services rendered at Ascend can also be discussed with Dr. David Maxwell at 704-279-0626 or [david@ascendpsy.com](mailto:david@ascendpsy.com)

**Acceptance of Terms**

We agree to these terms and will abide by these guidelines.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Parent (if client is a minor): \_\_\_\_\_ Date: \_\_\_\_\_

Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

**Child Intake Form**

Childs Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**About Your Child's Routine**

- What kind of physical exercise does your child get? \_\_\_\_\_
- How much coffee, cola, tea, or other caffeine does your child consume each day? \_\_\_\_\_
- Is your child's eating restricted in anyway? \_\_\_\_\_ Why? \_\_\_\_\_
- Sleep: Bedtime \_\_\_\_\_ Wake Up time \_\_\_\_\_
- Does your child have any problems getting enough sleep? \_\_\_\_\_ If yes please explain  
\_\_\_\_\_

**About Your Child's Health**

- Who is your child's pediatrician? \_\_\_\_\_
- Last doctor's visit? \_\_\_\_\_
- Any Concerns shared by the doctor? \_\_\_\_\_
- Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has/had  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Allergies \_\_\_\_\_
- List medications or drugs your child has taken in the last year  
\_\_\_\_\_  
\_\_\_\_\_
- List all prior counselors/dates/reasons  
\_\_\_\_\_  
\_\_\_\_\_
- Anything else you are concerned about? \_\_\_\_\_

**Other**

- Is your child or older sibling in a gang? \_\_\_\_\_ Has your child or sibling used drugs? \_\_\_\_\_  
If yes, describe which drugs, frequency, age at first use, and  
\_\_\_\_\_  
\_\_\_\_\_
- Has this child ever been pregnant or fathered a child? \_\_\_\_\_

**Physical Behavior – check any that are concerns**

Aggressive	Failing in school	Lacks respect for authority	Rocking or other repetitive movements
Argues	Fire starting	Learning disability	School avoiding
Assaults	Head banging	Masturbation	Self-harming
Bullies others	Hitting	Mute, refuses to speak	Sexually active
Cheats	Hyperactive	Nightmares	Shy
Complains of feeling sick	Inappropriate sexual behavior	Obedient	Smart-alecky
Cruel to animals	Inattentive	Oppositional	Speech difficulties
Developmental delays	Independent	Picks on others	Stealing
Dropping out of school	Inflicts pain on others	Rages	Temper tantrums
Eating issues	Intimidates others	Recent move	Teases others
	Violent	Uncooperative	Wetting/soiling of bed/clothes

**Emotional Behavior – check any that are concerns**

Bigoted	Intimidated by others	Negativism	Sexually preoccupation
Bullied by others	Likes to be alone	Nervous	Suicide talk or attempt
Disobedient	Low frustration tolerance	Noncompliant	Teased
Disrupts family activities	Lying	Poor concentration	Unhappy
	Manipulates	Sad	Withdrawn

**Any other characteristics or concerns**

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