



Name: _____ Date: _____

Susanne Chirco – Counselor, LLC

Susanne Chirco, MS, CRC, CAADC

Certified Rehabilitation Counselor – Certified Advanced Alcohol & Drug Counselor

Registration

Adult

Youth

Individual

Group

Anger Mgmt.

Parenting

SUD

Last Name: _____ First: _____ Middle Initial: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Voicemail: _____ Yes / No

DOB: _____ Gender: Male/Female/Other: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Spiritual Beliefs: _____

RESPONSIBLE PARTY INFORMATION (If different from above): Relationship to client: _____

Last Name: _____ First Name: _____

Address: _____ Phone: _____
City State Zip Voicemail: Yes / No

***Emergency Contact:** _____ **Phone:** _____

I authorize Susanne Chirco- Counselor, LLC, to disclose my Client Health Information to the following person(s)

Name: _____ **Phone:** _____ **Relationship:** _____

Name: _____ **Phone:** _____ **Relationship:** _____

In consideration of all counseling services provided by Susanne Chirco - Counselor, LLC to the client named above, I agree to pay Susanne Chirco - Counselor, LLC all fees and charges made for services, which may include the cost of collection and/or reasonable attorney's fees. Payment is due and payable when services are rendered. A late charge fee of \$25.00 will be added to the account for all charges not paid within 30 days. This fee will roll over each month and an additional \$25.00 for each month thereafter. *If your account is not brought current within three (3) months, services will cease and your account will be turned over to a collection agency. If your account is turned over to a collection agency you will be responsible for the 35% service charge.*

I hereby certify that the foregoing information is true and complete. I have read and hereby agree to be bound by the terms of these agreements as set forth. A photocopy of this form shall be valid as the original. I understand it is my responsibility to notify Susanne Chirco - Counselor, LLC of any changes to the above information.

I certify that the information provided is complete and accurate to the best of my knowledge.

Signature of Patient/Responsible Party: _____ **Date:** _____

Print Name of Client or Responsible Party: _____ **Date:** _____



Susanne Chirco – Counselor, LLC – 795 Holly Lane – Waverly, TN – 37185
(931) 296-9813 office – (931)-296-9853 fax



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Insurance Information

Primary Insurance

Policy Holder Name

DOB

Last 4 SSN

Policy Number

Group Number

Secondary Insurance

Policy Holder Name

DOB

Last 4 SSN

Policy Number

Group Number

1. Assignment of Benefits (AOB) Clause

"I authorize the release of any medical or other information necessary to process insurance claims. I also authorize and request payment of medical benefits to be made directly to Susanne Chirco, Counselor, LLC for services rendered. This authorization is valid until revoked in writing."

2. Financial Responsibility Clause

"I understand that I am financially responsible for all charges not covered by my insurance, including but not limited to co-pays, deductibles, and services not deemed medically necessary by my insurer. If my insurance plan requires a referral or authorization, I understand it is my responsibility to obtain it."

3. Insurance Billing Disclaimer

"I understand that while Susanne Chirco, Counselor, LLC may bill my insurance carrier as a courtesy, this does not guarantee that my insurance company will cover or pay for all services. I agree to be responsible for any amounts not paid by my insurer."



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Client Rights

1. You have the right to accept or refuse services.
2. If you agree to services, you have the right to change your mind at any time.
3. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
4. You have the right to be free from abuse, neglect, and exploitation.
5. You have the right to be treated with dignity and respect.
6. You have the right to appropriate services in the least restrictive setting available that meets your needs.
7. You have the right to be told about the program rules and regulations before you are enrolled, including the rules and policies related to restraints and seclusion.
8. Your legally authorized representative, if any, also has the right to be and shall be and shall be notified of the rules and policies related to restraints and seclusion.
9. You have the right to be told before admission:
 - The services you are eligible for.
 - The proposed plan of action for services.
 - The risks, benefits, and side effects of all services, if applicable.
 - The probable health and mental health consequences of refusing services, if applicable.
 - The other services that are available and which ones, if any, might be appropriate to you
 - The expected length of services.
10. You have the right to a service plan designed to meet your needs, and you have the right to take part in developing that plan.
11. You have the right to meet with staff to review and update the plan on a regular basis.
12. You have the right to refuse to take part in research without affecting your regular care.
13. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
14. You have the right to receive an explanation of your services or your rights if you have questions while you are an active participant.
 15. You have the right to make a complaint and receive a fair response from the organization within a reasonable amount of time.
16. You have the right to complain directly to the Owner, Susanne Chirco – Counselor, LLC, at any reasonable time. The owner's contact information will be provided at the end of this document.
17. You have the right to get a copy of these rights before you start services.
18. You have the right to have your rights explained to you in simple terms; in a way you can understand within 24 hours of your intake.

Client Name Printed

Date

Susanne P Chirco, MS, CRC, CAADC

Counselor Name Printed

Date

Client Signature

Counselor Signature

Inquiries & Grievance Contacts:

Susanne Chirco – 795 Holly Ln – Waverly, TN 37185 – (931) 296-9813



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Informed Consent

First Name

Last Name

☐ Yes

☐ No

Is a Parent/Guardian completing form?

Name - Relationship

Birth Date

Email

Street Address

City, State, Zip

Susanne Chirco – Counselor, LLC

We are a certified counseling office with several years of experience specializing in various counseling. We value our relationship with our clients and believe that such relationship is the beacon in the healing process.

We believe that everyone is unique and has their own way of addressing resolutions. Thus, we believe in a wellness model that helps our clients empower themselves by focusing on what works for them and not in a systematic approach that provides a generic procedure, working on one treatment. One's journey is not the same as the other.

HIPAA Acknowledgment

"I acknowledge that I have received and reviewed the Notice of Privacy Practices (HIPAA) for Susanne Chirco, Counselor, LLC, which outlines how my medical information may be used and disclosed.

Client's Rights

1. Unless there is an emergency, all the therapy sessions are private and confidential except for specific situations described below:
 - a. Child, elder or dependent abuse,
 - b. Expressed threats of violence toward an ascertainable victim,
 - c. Detailed planning or concrete signs of future suicide attempts,
 - d. Sharing information is necessary to facilitate client care across multiple providers,
 - e. Sharing information is necessary for the treatment,
 - f. Requests from legal and administrative institutions.
2. With the Client's prior written consent, the Counselor may legally speak to another healthcare provider or Client's family members in emergency situations. The Client may direct the Counselor to share information with whomever the Client desires, and the Client may change his/her mind anytime and revoke the permission.
3. The Counselor is allowed to keep brief notes of the therapy session which shall be kept in strict confidence. The Client may, at any time, request a copy of the notes kept during the therapy session.
4. The Client may ask questions about what to expect during and the result of the therapy.
5. The Client may decline to proceed the therapy as to the techniques which may be conducted by the therapist.
6. The Client may cease to continue therapy anytime, without any impediment and may return to therapy anytime.
7. The therapist has the right to dismiss the Client from the course of therapy.



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I understand that Susanne Chirco, MS, CRC, CAADC, is not a licensed therapist currently. Susanne Chirco, MS, CRC, CAADC is a Master Level Counselor and Certified Rehabilitation Counselor and a Certified Advanced Alcohol & Drug Abuse Counselor. A **Certified Rehabilitation Counselor's Scope of Practice** allows the following: Rehabilitation counseling is a systematic process that assists people with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions.

Counseling Treatment Intervention

The application of cognitive, affective, behavioral, and systemic counseling strategies which include developmental, wellness, pathologic, and multicultural principles of human behavior. Such interventions are specifically implemented in the context of a professional counseling relationship and may include, but are not limited to: appraisal; individual, group, marriage, and family counseling and psychotherapy; the diagnostic description and treatment of persons with mental, emotional, and behavioral disorders or disabilities; guidance and consulting to facilitate normal growth and development, including educational and career development; the utilization of functional assessments and career counseling for persons requesting assistance in adjusting to a disability or handicapping condition; referrals; consulting; and research (CRCC, 2024).

A **Certified Advanced Alcohol & Drug Abuse Counselor's Scope of Practice** may provide the following services: The practice of a Certified Alcohol and Drug Counselor (CADC) consists of the Twelve Core Functions, including screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, report and record keeping, consultation with other professionals in regard to client treatment and services, and referral to treat addictive disorder or disease and help prevent relapse (NCASPPB, 2024).

Acknowledgement

I have reviewed this Professional Counseling Informed Consent Agreement.

I have read and reviewed the Client's Rights Agreement.

I accept and understand both agreements and consent to counseling.

_____ Client Name Printed	_____ Date	Susanne P Chirco, MS, CRC, CAADC _____ Counselor Name Printed	_____ Date
_____ Client Signature		_____ Counselor Signature	



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24-Hour Notice – Cancellation Policy

When you have booked an appointment with our office, we are setting aside a dedicated time slot specifically for you. We ask you to contact us should you need to reschedule this appointment and that you provide at least 24-hour notice. By providing this courtesy, it makes it possible to share the time reserved for you to another patient who may be in need and able to accept.

There is a charge of \$40.00 for a no show/no call without at least a 24-hour advance notice.

**Repeated cancellations/missed appointments will result in pre-payment of services prior to scheduling appointment. **

In our practice, each client receives this unique type of reservation. As you schedule your appointment, we begin to ensure materials are prepared and readily available for your next visit. Except in the event of an emergency for another client, you can expect us to be prompt; in turn, we would welcome the same courtesy from you.

_____	_____	Susanne P Chirco, MS, CRC, CAADC	_____
Client Name Printed	Date	Counselor Name Printed	Date
_____		_____	
Client Signature		Counselor Signature	



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POLICIES AND PROCEDURES

PROFESSIONAL SERVICES

The regular office hours, at this time, for Susanne Chirco, MS, CRC, CAADC, are currently:

MONDAY **THURSDAY** **FRIDAY** **9:00 am – 5:00 pm**
TUESDAY: 2:00 pm – 5:00 pm
WEDNESDAY: CLOSED

There is an answering machine, please leave a message if we are not able to take your call. If it is after hours or you are unable to reach your counselor during an emergency, please do one of the following:

CALL 911 or 988 **CALL 1-800-274-5637 (adults)** **CALL 1-888-3701 (children)**
Or go to your nearest EMERGENCY ROOM.

BENEFITS AND RISKS OF COUNSELING

People who are considering counseling should realize they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives, etc. They may change employment, begin feeling differently about themselves, and may change other aspects of their lives. While the professional staff will assist the client in effecting change, we cannot guarantee a specific outcome. People participating in counseling, ultimately, are responsible for their own growth or lack thereof.

FEE POLICY

Payment for all counseling services is due at the time services are rendered. The fee is based upon either a 45-min. session, 90-min. intake session, scored assessment, 60-min. group counseling session (which includes books, materials, and a certificate for the courts if required). **Cancellations are required with a minimum of 24-hour notice to avoid a \$40.00 cancellation fee.** At this time, Susanne Chirco – Counselor, LLC **is not** registered to take insurance payments as of this date, therefore, all payments must be by cash or credit card until this process is completed.

CONFIDENTIALITY

Tennessee Department of Health, (TDH), HIPAA Policies Privacy Policy Title:

Uses and Disclosure of Client Information Policy Number: 105

“TDH shall not use or disclose any PHI about a client of TDH’s programs or services without a signed authorization for release of that information from the client, or the client’s personal representative, unless authorized by this policy, or otherwise authorized by state or federal law.” Meaning, confidentiality is controlled by the client. As a rule, information shared in a session with a counselor will remain confidential.

There are 2 exceptions to this rule, in the case of an emergency, where the counselor believes the client may be at risk of harming themselves or another, confidentiality may be breached. In the case of suspected abuse, in any form, be reported to the Department of Human Services. This includes children, elderly people, and people with disabilities.

Parents of children under the age of 16 will have access to pertinent information related to their minor child, unless the courts have terminated parental authority. Both parents may have access to the records and information regarding minor children, again, unless the courts have dictated otherwise.

Communication with parents will not be done through social media. This includes email. Any communications via email from this office does not go through a secure server, therefore, would not be HIPAA compliant.

CREDENTIALS

Susanne Chirco has a Master’s Degree in Rehabilitation Counseling and is Certified through the Commission on Rehabilitation Counselor Certification. She is also a Certified Advanced Alcohol & Drug Counselor and is certified through the Tennessee Certification Board.



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NOTICE OF PRIVACY PRACTICES

This Notice describes how anger management/substance abuse/medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I am required by federal laws to make uses and disclosures of your protected health information (PHI) for the purposes of treatment, payment, and health care operations known to you. Such information may include documenting your symptoms, ongoing treatment progress, and diagnoses.

Personally identifiable information about your health, your health care, and your payment for health care is called Protected Health Information (PHI). We must safeguard your Protected Health Information and give you this notice about our privacy practices that explain how, when and why we may use or disclose your Protected Health Information. Except in the situations set out in the Notice, we must use or disclose only the **minimum necessary** Protected Health Information to carry out the use or disclosure.

Examples:

When I submit requests for payment from your health insurance company, I am required to provide them with treatment dates, diagnoses, and demographic information (ie. Address, age, etc.),

When I submit records for payment to various state departments (is. TDOC, DCS), I am often required to give all of the above and case notes regarding the type of treatment I am providing, including your response, and,

You may obtain a copy of the Notice by calling us at (931) 296-9813 and asking us to mail you a copy or by asking for a copy at your next appointment.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records I maintain are the physical property of Susanne Chirco, M, CRC, CAADC. You have the following rights with respect to the laws; you may give written requests to:

Restrict certain uses and disclosures of health information. I am not required to grant the request but will comply with any request granted,

Inspect and copy your health record and billing record,

Have your healthcare record amended to correct incomplete information. If your request is denied, you can file a statement of disagreement with being attached to the file and sent with any disclosures of that information,

Receive a list of disclosures of you information that I have given to others, and,

Have communication of your PHI done in an alternative means or at an alternative location.

MY RESPONSIBILITIES

I am required to:

Maintain the privacy of your PHI as required by law,

Provide you with written notice of the Client Bill of Rights and the information I collect and maintain about you,

Abide by the terms of this notice,

Notify you if I cannot accommodate a requested restriction or request,

Accommodate your reasonable request for an accounting of disclosure information,

Accommodate your request for an accounting of disclosure of information,

Have a contingency plan in place in the event of my becoming incapacitated where I have assigned

Professional individuals to contact patients, maintain records, billing, or other duties required to maintain or close the office, and,

Inform you that I do not communicate with patients through social media. Any communication utilizing my email address does not go through a secure email network therefore, this is not the preferred method of communication.

FILING A COMPLAINT

If you feel your rights have been violated, you may file a written complaint with me or you can file a complaint with the Secretary of Human Services at: 200 Independence Ave. SW, Washington DC, 20201, 1-877-696-6775 or online at: www.hhs.gov.

USES AND DISCLOSURES ALLOWED BY THE PRIVACY RULE

Patient Contact: I may contact you regarding appointments with information about alternative treatments or with information about other health-related benefits and services which may be of interest to you.

Child Abuse & Neglect: I am a mandated reporter and am required by law to disclose information pertaining to the abuse or neglect of a child or elderly person.

Threat of harm to self or others: Using professional judgment, I am required to report to the appropriate authorities, if you, or your child, threaten in earnest to harm self or someone else. If you, or your child, in earnest, disclose a threat against another, or self, I am required, by law, to relay that information to the person being threatened, if known or to the appropriate authorities.

Judicial Proceedings: I cannot disclose your private information without your written consent unless directed to do so by a proper court order or subpoena from a judge.

I have received the Notice of Privacy Practices and have been provided with an opportunity to review it.

Signature of responsible party: _____ Date: _____



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Adlerian Therapy Introduction Form:

Adlerian Therapy, developed by Alfred Adler, is a humanistic and goal-oriented approach to counseling that emphasizes an individual's capacity for growth, responsibility, and community connection. Adlerian Therapy is understanding a person's unique lifestyle, which encompasses beliefs, values, and early memories that shape how they interpret and respond to the world. Adlerian counselors aim to foster encouragement and help clients identify and modify self-defeating thoughts while promoting social interest, meaning, and cooperation.

What brings you in to see me today?	
If you mentioned a few things, please tell me which one troubles you the most?	
What do you think your life would be like without you being troubled with this?	
What type of person would you like to be in the next 6 months?	
How would you like your life to be in the next year?	
What would need to happen to know our work together has been completed?	
Is there anything else about you, you would like to tell me?	



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