

Triple Moon Healing Center

The Healing Practice of
Rev. Nancy McMillan-Davison



22 Sonia Drive, Marlborough, MA 01752 Phone 508-251-0111

P.O. Box 187 East Boothbay, Maine 04544 207-350-1675 www.triplemoonhealingcenter.com

Instructions:

1. Fill Out All Three Forms Below
 - a) Confidential Patient Symptom Profile
 - b) TRIPLE MOON HEALING CENTER ACKNOWLEDGEMENT AND AGREEMENT
 - c) Agreement To Pay
 - d) Credit Card Authorization Form if you choose to pay by credit card

2. Mail or Email Form to Triple Moon Healing Center
 - a) Mailing Address:
 - In Massachusetts: 22 Sonia Drive, Marlborough, MA 01752
 - In Maine: Triple Moon Healing Center, East Boothbay, Maine 04544
 - Email information: triplemoonhealingcenter@gmail.com

Any questions, call Triple Moon Healing Center

Massachusetts: 508-251-0111

In Maine: 207-350-1675

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CONFIDENTIAL PATIENT SYMPTOM PROFILE

Name _____ Date _____

Address _____

Age _____ Date of Birth _____ Male/Female _____

Occupation _____

Marital Status M S D Children (Ages) _____

Previous Illnesses or Hospitalizations _____

Current Medications and/or Treatments (include specific condition being treated)

Family History (circle if yes) Heart Disease Diabetes Cancer Obesity

Alcohol/Drug Addition Mental or Emotional Problems

Other

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Please Circle One

Do you get cold hands and/or feet?	Often	Sometimes	Never
Do find it difficult to sustain concentration or forget things easily?	Often	Sometimes	Never
Do you get weepy, depressed and find it hard to motivate yourself?	Often	Sometimes	Never
Do you get anxious, panicky or shaky inside?	Often	Sometimes	Never
Do you become impatient, irritable or aggressive too easily?	Often	Sometimes	Never
Do you crave sugar or sugary products?	Often	Sometimes	Never
Do you sign and yawn a lot?	Often	Sometimes	Never
Do you suffer sharp shooting pains in the body?	Often	Sometimes	Never
Do you experience twitching of the face or eye muscle?	Often	Sometimes	Never
Do you experience heart palpitations?	Often	Sometimes	Never
Do you wake up feeling tired?	Often	Sometimes	Never
Do you get stiff or painful joints?	Often	Sometimes	Never
Do you suffer from a sexually transmitted disease?	Often	Sometimes	Never
Does your head feel fuzzy, as if it's full of cotton?	Often	Sometimes	Never
Do you suffer from headaches?	Often	Sometimes	Never
Do you have excessive hair loss or split ends?	Often	Sometimes	Never
Are your fingernails soft or do they flake or crack?	Often	Sometimes	Never
Do you catch colds or infections easily?	Often	Sometimes	Never
Do you suffer from yeast infections or thrush?	Often	Sometimes	Never
Do you suffer from blocked sinuses and sinus headaches?	Often	Sometimes	Never
Do you have post-nasal throat or chest mucus?	Often	Sometimes	Never
Does the skin on your lips, hands or feet crack?	Often	Sometimes	Never
Do rich food disagree with you?	Often	Sometimes	Never

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Do you feel a tight band around your chest, head, throat or abdomen? Often Sometimes Never

Do you suffer from hernia, hemorrhoids or varicose veins? Often Sometimes Never

Do suffer from cystitis or urethritis? Often Sometimes Never

Do you bruise easily or do cuts take a long time to heal? Often Sometimes Never

Your Signature _____ Date _____

Please print your name _____

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TRIPLE MOON HEALING CENTER CONSENT FOR INTUITIVE COUNSELING

Rev. Nancy McMillan is an intuitive counselor holding a Bachelor's Degree in Psychology and a Master's Degree in Counseling Psychology. She provides individual, group and family therapy.

WHAT TO EXPECT FROM TREATMENT

Studies of psychotherapy indicate that most clients benefit from treatment and experience improvement in the problem areas for which services are sought. However, treatment benefits cannot be guaranteed. Response to therapy is different for each client and should be discussed on an ongoing basis.

Counseling can involve a variety of different activities, which vary from client to client. In general, the therapist will assess your problems and then provide therapeutic services designed to resolve or reduce the problems. There may be individual work with you or your child, discussions with you possibly including ways to help yourself or your child outside of therapy, and/or family sessions. Therapy may focus on feelings, thoughts, relationships and/or behaviors. With young children, therapy generally includes play activities used as a means of understanding and communicating with the child.

Assessment procedures may include standardized tests and techniques to aid in diagnosis and treatment. Assessment for counseling will not generally follow the procedures for a child custody evaluation and the therapist may refuse to give an expert opinion in court.

CONFIDENTIALITY/PRIVACY

Historically, counseling has been associated with complete confidentiality between the client or family and the clinician. Currently, both law and professional ethics requires counselors to maintain complete confidentiality in the vast majority of cases. In these cases, the counselor cannot release any information about you or your family without your express permission. However, as a result of legal developments, there are some exceptional circumstances in which counselors/therapists are required to communicate information about therapy outside of the client or family. These exceptions include the following situations:

- The client presents a clear and present danger to himself or herself and refuses to accept appropriate treatment.

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- The client communicates to the counselor a threat of physical violence against a clearly identified or reasonably identified victim, or the counselor has a reasonable basis to believe there is a clear and present danger of physical violence against such a victim.
- The client introduced his or her mental condition as a defense in a legal proceeding.
- In child custody or adoption cases, the judge determines that the counselor has information bearing significantly on the client's ability to provide suitable care.
- The client initiates legal action against the counselor
- The counselor has grounds to believe a child under the age of 18 or an elderly person (over age 60), or a handicapped adult, has been or is at risk of being abused or neglected.
- The counselor has reason to believe a health care professional has engaged in professional misconduct
- A judge orders the counselor to release client information.
- Any matter brought to the client's attention by a child or either parent regarding the child may usually be revealed to either or both parents. Matters that are irrelevant to the child's welfare may be kept in confidence. The decision whether to disclose relevant information is a matter of the counselor's professional judgement.

Please refer to the "Notice of Privacy Practices" handout for addition information about compliance with HIPAA law relating to privacy and our practices. Rev. Nancy McMillan currently handles her own records, billing and appointment scheduling. In the event she hires additional help, she will have the same business associate agreement (contractual agreement in order to insure confidentiality) she current has in place with any therapist or counselor she may consult with to improve patient care or to cover for her when she is on vacation.

If you do NOT consent for Rev. Nancy McMillan to consult with other mental health professionals affiliated with Triple Moon Healing Center who are contractually bound to maintain your confidentiality while assisting her, please check and initial here _____

Mail, Email or Phone Contact from Triple Moon Healing Center

As part of our ongoing operations, on an infrequent basis, we may sometimes send our clients and former clients information about our services such as a newsletter, or birthday or Christmas greeting, either by mail or email. If you prefer we do NOT put you on our mailing list or contact you regarding anything except your current treatment or billing, please initial _____

_____ **for myself and/or as parent or legal guardian of** _____ indicate by my signature on this form that I consent to the evaluation/treatment process with Rev. Nancy McMillan. I understand this process may include myself, my child and/or family members. I understand and consent to the conditions

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described above. I also acknowledge that I have received the Notice of Privacy Practices on the following pages and have been informed of the exceptions to confidentiality as described above.

Signature _____ Date _____

This is a strictly confidential patient medical record. Redislosure or transfer is expressly prohibited.

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ADDITIONAL AGREEMENT FOR SPIRITUAL COUNSELING

I, _____, the client agree to meet with Rev. Nancy McMillan, Spiritual Counselor/Psychotherapist at the appointment times and place we have agreed on, starting _____ for sessions of 60 minutes each.

I have read the following materials on spiritual counseling/therapy which have been provided to me:

1. Privacy Practices of Triple Moon Healing Center
2. Fee Agreement
3. Consent for Treatment

I believe I understand the basic ideas, goals and methods this counseling and spiritual therapy work. I have no important questions or concerns that Rev. McMillan has not discussed. In my own words I understand the following:

1. I am coming to Triple Moon Healing Center for assistance with some life issues and to work on connecting spiritually. Any issues not listed above, I have listed here:

2. The main methods to be used in this guidance work are:
 - a) Talk
 - b) Homework, written, oral and meditative
 - c) Meditation and relaxation techniques
3. During these sessions, we will focus on working towards the goals listed above. I understand that reaching these goals is not guaranteed.
4. I understand that I will have to do the following things/take the following actions:
 - a) Complete homework and other assignments
 - b) Keep a journal of my feelings, thoughts and ideas that come to me.

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With enough knowledge, and without being forced, I enter into work with Rev. Nancy McMillan. I will keep her fully up to date about changes in my feelings, thoughts, behaviors and experiences. I expect up to work together on any difficulties that occur, and to work them out in my long-term best interest.

At the end of five sessions, we will evaluate our progress and many change any parts of this agreement as needed. My goals may have change in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will attempt to make changes in this agreement and I may stop working with Rev. McMillan after giving her at least 7 days notice of my intentions and meeting with her one last time.

My signature below means that I understand and agree with all of the points above.

Signature of Client

Date

I, Rev. Nancy McMillan, have discussed the issues above with the client. My observation of this client's behavior and response give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed consent.

Rev. Nancy McMillan

Date

_____ Copy accepted by Client _____ Copy kept by Guiding Spirit

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FEE AGREEMENT

- 1. FEE FOR KEPT APPOINTMENTS:** Your fee will depend upon your insurance coverage. Although Triple Moon Healing Center does not accept insurance, if you have health insurance that would aid in payment, your fee per 60 minute session shall be the cost of your co-payment (\$10, \$20, \$40 or \$50). Proof of insurance is required. The standard fee for a 60 minute counseling session without proof of insurance is \$65.00. Please discuss with Rev. McMillan if you will have a hardship paying this fee and she may be willing to work out a fee with you. You alone are responsible for paying for the services and appointments at Guiding Spirit.
- 2. SPIRITUAL/PSYCHIC DEVELOPMENT FEE:** If you are working on psychic and spiritual development, this is a 12 session program at the total cost of \$240.00. You may pay in full at the time of your first session, pay the balance owed any time during the program or pay on a weekly basis of \$20.00 per session.
- 3. FEE FOR MISSED APPOINTMENTS:** When you schedule an appointment with Rev. Nancy McMillan the time is reserved for you. There is no fee if you cancel an appointment more than 24 hours in advance of the appointment. **If you cancel or do not keep an appointment without giving 24 hours notice, you will be charged a fee for the time you had reserved.** Exceptions: 1) If you are ill and do call before the appointment time to cancel your appointment there will be no charge. 2) If you reschedule and keep an appointment that occurs within three days of a missed appointment, you will not be charged for the missed appointment. 3) One missed appointment fee per year will be forgiven. **All missed appointments that do not meet the exceptions above will be charged a fee of \$60.00.**
- 4. TELEPHONE CONSULTATIONS, REPORTS AND LETTERS TO OTHER PROFESSIONALS:** May be provided as a courtesy at no fee if they are infrequent and require less than 20 minutes. Most services requiring more time, such as reports, letters or conferences have a fee of \$20.00 per hour. Rev. McMillan wants to be available to her clients whenever they need her. However, it is important to note that there are other clients and appointments she must also be available for. She will accept an emergency phone call but must also limit the time on such calls. There is no charge for emergency phone

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calls, however those calls that go over 30 minutes will need to be charged at the rate of \$30.00 per hour.

5. THE FINAL RESPONSIBILITY FOR PAYMENT OF ALL FEE IS YOURS.

Occasionally Rev. Nancy McMillan and Triple Moon Healing Center may increase their standard fees. At that time, your fee will be adjust to the new fee, this agreement will be terminated and you will be asked to sign a new agreement which reflect the new fee.

PAYMENT ARRANGEMENTS: Payment of your fee is due at the time of each session and payable by check, cash or credit card in the amount of \$ _____.

Collection Procedures: Rev. Nancy McMillan and Triple Moon Healing Center reserves the right to collect any unpaid balance due. If a client is not making regular payments on an account balance under an alternative payment arrangement, they may use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections actions will become part of your credit record. Clients will be notified in writing before an account is referred to collections,

I have read and understand the above fee agreement, and I agree to abide by its terms.

Name (Parent/Guardian must sign for a minor)

Date

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CREDIT CARD AUTHORIZATION FORM

If you would like to pay by credit card, you can expedite payment at each session by completing the following information and returning it to us:

Name _____

Address _____

Home Phone _____

Cell Phone _____

Credit Card Type: MasterCard Visa

Credit Card Number _____

Expiration Date: _____

I authorize Triple Moon Healing Center to use this credit card number. I understand that payment for services are paid in full at the time services are rendered. I understand that all sales are final.

Signature _____ Date _____