## Client Information

Date: _____ Referred by_____ May we thank them for the referral? ☐ Yes ☐ No

**A. Identification**

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Apt:_____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ E-mail: _____

Which numbers/email listed above may we leave messages on? _____

Give Name and Address of person responsible for payment if different from above:_____

_____

**B. Medical Care**

*Please list all Physician Names & Numbers:

_____

_____

Medication: _____ Dosage: _____ Reason: _____ Date Started: _____

Medication: _____ Dosage: _____ Reason: _____ Date Started: _____

List any serious accidents, illnesses, operations, or hospitalizations and what year. _____

_____

**C. Employment**: Occupation:_____

**E. Family of Origin**

| Relative | Name | Age | Illness | Education | Occupation | Quality of Relationship |
|---|---|---|---|---|---|---|
| Father | _____ | _____ | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ | _____ | _____ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Step-Father | _____ | _____ | _____ | _____ | _____ | _____ |
| Step-Mother | _____ | _____ | _____ | _____ | _____ | _____ |
| Brother(s) | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |
| Sister(s) | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |

**F. Marital History**

| Spouse's Name | Years Married | Previous Marriage(s) | Reason for Divorce |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

**H. Children**

| Name | Age | Gender | School & Grade | Behavioral or Adjustment Problems? | Quality of Relationship |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

**I. Reasons for Seeking Counseling:**

_____

_____

**J. Attempted Solutions**

How have you attempted to solve the problems that have brought you to therapy? _____
_____
_____

**K. Previous Counseling Experience**

Have you ever received counseling before? When? _____
_____

| Therapist's Name | Clinic Name | City, State | Reason(s) |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

What was helpful about these experiences? _____
_____
_____

What was unhelpful? _____
_____
_____

**Emergency Contact Person**:_____Address:_____
Phone:_____
*This will only be used in the event of a medical or psychological emergency in our offices.

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. *Please rate every item*.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Concern | | | | | Moderate Concern | | | | | Extreme Concern |

| | | | |
|---|---|---|---|
| _____ | Anger | _____ | Mood Swings |

_____ Abuse Victim

_____ Aggression/Violence

_____ Anxiety

_____ Attention/Concentration

_____ Compulsions

_____ Confusion

_____ Depression

_____ Divorce/Separation

_____ Education

_____ Eating/Appetite Problems

_____ Fears of Specific Objects or Events

_____ Grieving/Mourning

_____ Impulsiveness

_____ Financial Problems

_____ Legal Problems

_____ Problems with Children

_____ Problems with Parents

_____ Problems with Social Relationship

_____ Religious and/or Spiritual Concern

_____ Self-Harming Behavior

_____ Sexual Concern

_____ Thoughts of Suicide

_____ Trouble Making Decisions

_____ Unhappy Most of the Time

_____ Unwanted/Intrusive Thoughts

_____ Use of Alcohol

_____ Use of Alcohol by Family Member

_____ Use of Other Drugs

_____ Use of Drugs by Family Member

_____ Work

| | | | |
|---|---|---|---|
| _____ | Marital Problems | _____ | Worry |
| _____ | Medical/Physical Problems | _____ | Hallucinations |
| _____ | Sleeping Problems | _____ | Smoking |
| _____ | Thyroid Problems | _____ | Other (specify)_____ _____ |

**PLEASE NOTE: If you feel suicidal after office hours or you are unable to reach your therapist at any time please call the suicide hotline at 1-800-227-8922 or your psychiatrist/physician emergency phone number. The counseling center staff does not operate as a crisis center and we do not carry pagers. We are only available during the hours your therapist is in the office. The assessment staff at Peachford Hospital is also available at 770-455-3200.**

_____

Client Signature

DISCLOSURE
(Please review and discuss any questions with your therapist)

The following information pertains to the treatment and financial policies of North Atlanta Counseling Associates, Inc. Please note that North Atlanta Counseling Associates, Inc. also does business as North Atlanta Center for Christian Counseling, Cumming Christian Counseling, Faithful and True Atlanta, Atlanta Stepfamilies, Atlanta Stepfamilies Stepping Ahead, Faithful and True Marriages, and Northwest Counseling Services. These names represent the same group. Please sign and date this form at the bottom of the page. We will be happy to provide a copy for your records. These names represent the same group. Please sign and date this form at the bottom of the page. We will be happy to provide a copy for your records.

## I. PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It may vary depending on the personality of the client and the therapist and the specific problems being addressed. There are a number of different approaches that can be utilized to work on the problems you hope to address. It is different from medical treatment in that it requires a very active effort and commitment on your part. In order to be successful you will need to work both in session and at home.

There are both benefits and risks to psychotherapy. The risks include experiencing uncomfortable levels of anxiety, sadness, anger, frustration, and a variety of other emotions. Psychotherapy has also proven to have many benefits for

people who undertake it. It often leads to a significant reduction of feelings of distress, and better relationships and resolutions of specific problems. There are no guarantees about what will happen. Please discuss any reactions and emotions experienced during psychotherapy with your therapist.

By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with your therapist. Therapy involves a commitment of time, money, and energy. If there are any questions about procedures please discuss them with your therapist when the issues arise. If your doubts persist, we will be happy to help you with a referral to another mental health professional.

## II. PROFESSIONAL RECORDS

Both law and professional standards require the keeping of appropriate treatment records. Because these are professional records they can be misinterpreted and/or can be very upsetting. If you wish to see your records please submit a request to your therapist and the center director. It is strongly recommended that these records be reviewed with your therapist to discuss their content. Clients will be charged an appropriate fee for any preparation time that is required to comply with an information request.

## III. MINORS

If you are under eighteen (18) years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from parents that they consent to give up access to your records. If they agree, I will provide them only with general information on how your treatment is proceeding unless I feel that there is a high risk that you will seriously harm yourself or another, in which case I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before any information is disclosed I will discuss the matter with you and attempt to resolve any objections or concerns you might have.

## IV. CONFIDENTIALITY

In general, the confidentiality of all communications between a client and a counselor or therapist is protected by law, and I can only release information about our work to others with your written permissions. However, there are a number of exceptions.

In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he/she determines that resolution of the issues before him/her demands it. In the event a therapist receives a subpoena, there are separate charges apart from therapy that apply.

There are some situations in which I am legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment.

If I believe that a child, an elderly person, or a disabled person is being abused, I must (may be) required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am (may be) required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, I may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

These are rare situations that have seldom arisen in my counseling practice. Should such a situation occur, I would make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together.

While this summary of exceptions to confidentiality can be helpful in identifying potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. As you might suspect, the laws governing these issues are quite complex and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions of summaries of the applicable state laws governing these issues.

In order to insure the highest possible standard of care the staff of North Atlanta Counseling Associates, Inc., d/b/a/ North Atlanta Center for Christian Counseling, d/b/a Cumming Christian Counseling, d/b/a Faithful and True Atlanta, and d/b/a Northwest Counseling Services reserves the right to consult with staff members and appropriate professionals regarding your treatment. You will not be identified, and this consultation will be held in strict professional confidence.

Your signature indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

signature date

NAME: _____

## FEES

The usual therapy hour consists of 50 minutes. If the time runs past 60 minutes you will be charged for the additional time on a prorated basis. Exceptional circumstances must be discussed with your therapist. Time spent on phone calls between sessions will incur prorated hourly charges after the first 10 minutes.

## PAYMENT IS EXPECTED AT THE TIME OF EACH SESSION

Payment options are check, Visa, and Mastercard. A $35 fee will be charged for each returned check. Please discuss any unusual circumstances with your therapist. Sliding scale fees based on income and/or extreme circumstances may also be available.

**Telephone, video chat and text chat sessions:** $120

**Therapeutic email:** $25 per email or package of 5 for $100

**PLEASE NOTE: Except under extraordinary circumstances, clients will be billed the full fee for all appointments not canceled with at least 24 hours notice. You may leave a message on voice mail on weekends or after hours to cancel an appointment. Insurance will NOT pay for missed appointments. Scholarships will NOT be applied to missed appointments. If you are receiving financial assistance from our scholarship program please be aware that you will be charged the full session rate for appointments not canceled with 24 hours notice.**

I acknowledge responsibility for all fees incurred and agree that if it is necessary to collect my account through an attorney, collection agency, or other legal resources that I will be responsible for all cost of litigation and attorney's fees incurred.

## I have read and understood the above policies.

_____ _____

signature date

## VI. INSURANCE

The use of insurance poses risks that clients should be aware of in making decisions regarding counseling services. Most managed care companies and insurance panels will only provide limited reimbursement for services from "their" providers. Using insurance involves a clinician making a mental health diagnosis that will remain in your medical record where a variety of insurance companies might have access to them. The risk of confidentiality being violated increases when insurance papers are filed. For this reason we do not participate in managed care panels or insurance plans. We are happy to provide a receipt if you choose to file for insurance benefits, but as a center, we do not participate in managed care panels.

## 24 Hour cancellation policy

Please call or email at least 24 hours in advance to cancel an appointment. Failure to do so will result in a full charge. This charge cannot be billed to your insurance company or subsidized through the scholarship program.

The policy will be reconsidered in the event of illness or an emergency. Please discuss these situations with your therapist. Thank you for being considerate of the needs of our other clients.

_____ _____

signature date

# Additional Policies for Distance Therapy

The Internet and other technology now enable us to provide services outside of the Atlanta area. As a center, we operate under the laws of the state of Georgia. These laws and professional standards of the industry will apply to the work that we do.

We strongly encourage the use of encrypted communication channels for therapeutic work. Additional information on free encryption services is available on our website. Even with those tools in place, however, counseling via electronic format (Internet, email, and digital technology) has some risk of interception, which is beyond our control. This is particularly true if the equipment you are using belongs to an employer, as they have legal ownership rights to everything that passes through equipment that they own. For this reason, we discourage the use of employer-owned computers and networks for confidential counseling communications.

North Atlanta Counseling Associates, Inc. and its affiliates assume no liability or responsibility for technology breakdown, including intercepted emails, text messages, instant messages, and voicemails. If transmission is interrupted, we will make every effort to resume the counseling session. If a large block of time in a session is interrupted due to technology failure, the cost of the session may be prorated. We will need a photocopy of your drivers license sent to us. It can be faxed to us at 770-457-3046 or scanned and emailed to your therapist.

Professional standards require that we have emergency contact phone numbers in your local area. Please provide us with the following numbers.

Local Police Department:_____

Local Hospital: _____

Payment can be made by check prior to the session or by credit card at each session. If you desire to use a credit card, please complete the following information. We can accept Visa or Mastercard.

Credit Card Number: _____ Expiration: _____
Billing address for the card: _____
street

_____
City State Zip Code

Three digit privacy code on back of credit card._____

Authorization to charge card for each session _____
Signature

# PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("the privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have been given the opportunity to receive this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

North Atlanta Center for Counseling
2312 Peachford Road, Suite C
Atlanta, GA 30338

I, _____, understand and have been provided or I have denied a copy of the Patient Notification of Privacy Rights document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Patient Signature (or parent or legal charge) date

If legal charge, describe representative authority _____