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ADULT NEW CLIENT INFORMATION

BASIC INFORMATION

Name: ____ **Date of Birth:** ___________
Address: ___________________________________ **Marital Status: S / M / SP / D / W**
City: ______________________________ **Zip:** _____________ **Soc Security #**_______
Phone Number: (h)_____________**(w)**__________________**(c)**___________________
Emergency Contact: ___________________ **Phone:**____________________________
Relationship to you: ____
Referred by: ________________________________ **Phone:** _______________________
Reason for Referral:
____

EMPLOYMENT

Employer: _____________________________ **Job Title:** _______________________
Employer's Address: __________________________ **Phone:**___________________
City: _______________________________ **State:** ___________ **Zip:**

GUARANTOR INFORMATION

Full Name: ____________________________________ **Phone:** ______________________

Address: ____ **City:**______________________

State:____**Zip:**________

INSURANCE INFORMATION

We will file your insurance for you as a courtesy; however, you are responsible for any deductibles, co-pays, and services that your insurance does not cover. It is your responsibility to be aware of the benefits that your insurance company provides.

Insurance Company: ____
Policy Holder: ____________________________**Date of Birth:**_____________________
Social Security #__________________________

Family Information

Name: ___________________________**Age**____**Marital Status: M / S/ SP/ D/ W**
Occupation: _______________________ **Education Level:**___________________

Name: __________________________ Age___Marital Status: M/ S/ SP/ D/ W
Occupation: ____________________ Education Level:____________________

CHILDREN IN HOME:
Child's Name: ______________________Date of Birth:_____________Age:_____
Child's Name: ______________________Date of Birth:_____________Age:_____
Child's Name: ______________________Date of Birth:_____________Age:_____
Child's Name: ______________________Date of Birth:_____________Age:_____
OTHER PEOPLE LIVING IN HOME:
Name: ________________________Age:_____Relationship to you:________
Name: ________________________Age:_____Relationship to you:________
Name: ________________________Age:_____Relationship to you:________
Name: _______________________ Age:_____Relationship to you:________

If you have been previously married or involved in a long-term relationship, please indicate below:
Dates of previous relationship/marriage:
Dates of previous relationship/marriage:
Dates of previous relationship/marriage:

Medical Information

Physician's Name: ________________________________ Phone: _____________
Previous illnesses, injuries, hospitalizations: _____________________________
____
Are you currently under the care of a physician for any chronic or acute medical conditions: _____ IF YES, please note:
____

Are you currently experiencing any of the following: difficulty sleeping, changes in weight (gain or loss), eating difficulties, restlessness, trouble concentrating?
Current medications and dosages: _______________________________________
Previous psychological evaluation?____If YES, give date(s) and evaluation(s):
____

Psychological / Family-History

Have you received previous outpatient treatment? _________________________
If YES, give approximate dates and therapist's name:______________________
Have you received previous inpatient treatment? ___________________________
If YES, give date and name of hospital:_____________________________________
Do any family members have a history of inpatient or outpatient psychiatric care? ____
If YES, list their relationship to you and condition (e.g. maternal aunt-

depression):____

Do any family members have a history of alcohol or drug abuse? _____________

Have you experienced any of the following, (please circle all that apply):

Domestic Violence	**Sexual Abuse**	**Physical Abuse**
Drug Addiction	**Alcohol Abuse**	**Suicide Attempts**
Anxiety	**Depression**	**Eating Disorders**

Payment is expected at the time of your appointment, unless other arrangements have been made in advance.

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your psychotherapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Theoretical Views

We are a family-oriented treatment center. When someone comes into our program, patients and their families can expect a complex system of therapies. This is done after being assessed by professional staff to learn what the patient needs. These therapies are all interrelated with every layer of the family system being addressed. We understand that family participation may not apply to every individual we see. Our theoretical approach for adults is Directive and Non-Directive Therapy to assess and identify the source of the problem. We then treat that source with a strategic incremental system of care.

Client Participation

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs completely while you participate in these therapy sessions.

Confidentiality & Records

Your communication with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my office. Additionally, I will always keep

everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privilege communication is your right as a client to have a confidential relationship with a therapist. The State of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.
Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

<u>Structure and Cost of Sessions</u>

I agree to provide psychotherapy for the fee of $150 per session, unless otherwise negotiated by you or your insurance carrier. Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you. Telephone calls will not exceed 10 minutes in duration. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, or Master Card are acceptable for payment, and I will provide you with a receipt of payment. Please note that there is a $35 fee for any returned check.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.
If your account is more than ninety days in arrears and suitable arrangements for payment have not been agreed to, we have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. <u>If your account is turned over to a Collections Agency, the 35% collections fee assessed by the agency will be added to your balance. An additional fee of $68.00 will be added to accounts forwarded to small claims court, in addition to any other legal fees our office incur.</u> In most cases, the only information we release about a client's treatment would be the client's name, address, nature of the services provided, and the amount due.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify me at least 48 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed, $150 for missed appointment. If your appointment is on Monday your notification must be done on Friday.

In Case of Emergency

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 24-48 hours. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

- **Call Ridgeview Institute at 770.434.4567 or Peachford Hospital at 770.454.5589**
- **Call 911**
- **Go to your nearest emergency room**
- **Call the Crisis Lines at 1.800.715.4225**

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, you relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature. Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients' secret. As much as I would like to, for your confidentiality, I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association and/or the American Counseling Association and/or the National Association of Social Workers. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with me as your therapist, and you are authorizing me to begin treatment with you.

Consent:

I consent to treatment, certify that the above information is accurate, and authorize the release of medical information to other necessary parties, including insurance claim requests.

____

Client Name (Please Print)

____ **DATE:** _______________

Client Signature

____ **DATE:** _______________

Therapist Signature