CLIENT INFORMATION

NAME _____AGE_____ Birthday_____ Today's Date_____

ADDRESS:_____
STREET CITY STATE ZIP

EMAIL_____

PHONE NUMBERS: IS IT OK TO LEAVE A MESSAGE ON YOUR PHONE? _____TEXT OK?_____

PREFERED # _____ OTHER _____

EMERGENCY CONTACT _____Relationship_____PHONE _____

DOES YOUR EMERGENCY CONTACT KNOW YOU ARE IN THERAPY? _____

Referred by/ How did you find out about me?_____

LIST ANYTHING SPECIFIC YOU WANT TO TALK ABOUT:

_____

_____

Are you taking any medication? ( ) Yes ( ) No If yes, please specify

_____

Have you ever been in counseling/therapy? ( ) Yes ( ) No

Have you been given a psychological diagnosis (if yes, please identify and/or describe)?

_____

Are you experiencing any medical problems? ( ) Yes ( ) No If yes, please specify

_____

Any history of drug or alcohol problems with family members? ( ) Yes ( ) No With you? ( ) Yes ( ) No

Do you feel suicidal? ( ) Yes ( ) No Have you ever attempted suicide? ( ) Yes ( ) No A family member? ( ) Yes ( ) No

Is there any other information you would like to include here?

Place a check mark if you have experienced these symptoms.

1. _____ I feel depressed recently
2. _____ I have lost the ability to enjoy life.
3. _____ I cry often for no apparent reason.
4. _____ I have recently gained weight.
5. _____ I have recently lost weight without trying to.
6. _____ My appetite is not what it used to be.
7. _____ I sleep too little.
8. _____ I sleep too much.
9. _____ I feel irritable most of the time.
10. _____ I am easily angered.
11. _____ When I become angry I lose control.
12. _____ I feel worthless most of the time.
13. _____ I have excessive guilt over things I have done in my life.
14. _____ I feel stressed most of the time.
15. _____ I have thoughts that life is not worth living.
16. _____ I have thoughts of harming myself.
17. _____ I have thoughts of ending my life.
18. _____ I have done things to harm myself.
19. _____ I have feelings of overwhelming anxiety and panic.
20. _____ I fear I am losing my mind.
21. _____ My mind races and it is hard to turn off my thoughts.
22. _____ I hear voices that others don't hear.
23. _____ I see people that others don't see.
24. _____ I believe that others are out to get me or to try and harm me.
25. _____ I am concerned about my use of drugs.
26. _____ I am concerned about my use of alcohol.
27. _____ Others are concerned about my use of drugs.
28. _____ Others are concerned about my use of alcohol.
29. _____ I have had legal consequences because of my drug or alcohol use.
30. _____ I have difficulty remembering events in my life.
31. _____ I have trouble remembering if an event happened or it was a dream.
32. _____ I have the feeling that my body is not my own.
33. _____ I feel the world around me is not real.
34. _____ I remember the past so vividly I relive it.

35. _____ I have recently experienced a significant loss.
36. _____ In my adulthood I experienced a significant loss.
37. _____ In my childhood/adolescence I experienced a significant loss.
38. _____ I have recently been physically assaulted.
39. _____ I experienced physical abuse growing up.
40. _____ I experienced emotional abuse by someone in my adulthood.
41. _____ I experienced emotional abuse during childhood/adolescence.
42. _____ I have recently been sexually assaulted.
43. _____ In my past I was sexually abused by someone.

Tana Hall, M.Ed., LPC

404-496-8262

INFORMATION AND CONSENT TO TREATMENT

(As required by HIPAA and the State of Georgia)

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), which is a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that I provide you with a Georgia Notice Form about the use and disclosure of your Protected Health Information for treatment, payment and health care operations. I have copies of our Georgia Notice Form for you to take or simply review. The Georgia Notice Form explains the HIPAA law and its application to your personal health information in greater detail. The law also requires that I obtain your signature acknowledging that I have provided you with this information at your first session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the information, and then I will ask you to sign this Agreement.

When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and outside our sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise.

SESSIONS: Individual sessions are customarily 50 minutes, including time spent scheduling appointments and paying fees. Longer or more frequent sessions can be arranged as necessary.

CANCELLATIONS: If you cancel a session less than 24 hours before it is scheduled or you do not show up for an appointment, you will be asked to pay the full fee for that session. If you are using insurance, they do not provide reimbursement for canceled sessions, so the total cost of the session is your responsibility.

PROFESSIONAL FEES: My hourly fee is $110 per session, unless otherwise agreed upon. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include letter writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. You may request an invoice.

CONTACTING ME: I have a confidential voicemail box (404-496-8262), at which you may leave a message. I do check messages regularly and will return calls as promptly as possible. You may also text me with logistical concerns, but not for therapeutic issues. If you need more immediate attention, you have several options: call a friend or another member of your support network; call your psychiatrist (if you have one) or your primary care physician; contact your local county mental health center, call the Georgia Crisis and Access Line (800-715-4225, they provide mobile assessments), go to the nearest emergency room, or dial 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY: The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that

you provide written, advance consent. Your signature on this Agreement provides written advance consent for activities such as those outlined below:
· If a client threatens to harm themself, I **may** be obligated to seek hospitalization for them or to reach out to the Emergency Contact, listed on this consent form, family members or others who can help provide protection.
·
There are some situations where I am permitted or required to disclose information **without** either your consent or your written Authorization:
· If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychotherapist-client privilege law. I cannot provide any information without your written authorization, or a court order, which in this case does not require your authorization. I will do everything to protect your privacy, when allowed by the law. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
· If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

There are some situations in which I am **legally obligated** to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about your treatment. These situations are unusual in my practice.
· If I have reason to believe that a child, disabled adult or elder person has been abused, the law requires that I file a report with the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.
· If I determine that a client presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS: You should be aware that, pursuant to HIPAA, I keep clinical records on you. Most of this constitutes your Protected Health Information. It may include information such as your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself or others, or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, or if information is supplied to me confidentially by others, you or your legal representative may examine and/or receive a copy of your clinical record, if you request it in writing. Because these are professional records, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

CLIENT RIGHTS: HIPAA provides you with rights with regard to your clinical record and disclosures of Protected Health Information. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement and the Georgia Notice Form. I am happy to discuss any of these rights with you.

MINORS & PARENTS: Clients under 18 years of age (who are not emancipated) and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and their attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger, is a danger to someone else,or intent on harming themselves, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections they may have.

BILLING AND PAYMENTS: In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. I will provide an invoice if you request one.

INSURANCE REIMBURSEMENT: If you have a health insurance policy, it may provide some coverage for mental health treatment. We can talk about if I take your insurance policy at the time. I will fill out forms and provide you with whatever reasonable assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees, at the time of service. It is very important that you find out exactly what mental health services your insurance policy covers and if they cover out of network providers.
If you use insurance to reimburse you for my services, you should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and the fee. I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in their computer. In some cases, they may share the information with a national medical information database. As with many medical conditions, a history of treatment might affect the purchase of new insurance in the future, although the current law states that it should not. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier. ***It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.***

DISCONTINUATION OF TREATMENT: Either of us may elect to discontinue treatment at any time. It is desirable to have a final closing session if a decision to discontinue treatment is made. If the decision to discontinue is made, and you still would like treatment,I will be glad to provide you with names of other referral sources.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE SEEN A COPY OF THE HIPAA GEORGIA NOTICE FORM DESCRIBED ABOVE. IF YOU HAVE ANY QUESTIONS, PLEASE ASK.

I voluntarily request services, accept the policies stated above, and acknowledge the full responsibility of all fees incurred.

SIGNATURE OF CLIENT OR GUARDIAN OF CLIENT UNDER 18 DATE

PRINTED NAME OF CLIENT