

Atlanta Family

C O U N S E L I N G

PERSONAL HISTORY

Please print

Date: _____

Name: _____

Current Address:

Permanent Address:

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Preferred method of contact: Home Cell Work Email

County of Residence: _____ **Gender:** Male Female **Age:** _____

Date of Birth: _____ **Language spoken at home:** _____

In case of emergency contact: _____

Relationship: _____ **Contact Number:** _____

Address: _____

Race: White, not Hispanic Hispanic Black, not Hispanic Asian

Native American Other: _____ **Ethnicity:** _____

Are you currently working?: Yes No **Occupation:** _____

Weekly Salary: _____ **Other income:** _____

1. **Name of Employer:** _____

2. **Employers Address:**

3. **How long have you been employed?:** _____

4. **If not employed, are you looking for employment?:** Yes No

5. **How were you referred to us:** _____

6. **Are you an American citizen?:** Yes No **Place of Birth:** _____

7. **Highest level of education completed:** _____

8. **Marital status (check one):**

- Single Divorced? How long? _____ Widow / Widower
- Married? How long? _____ Separated? How long? _____

9. **How many times have you been married?** _____

10. **How many people are currently living with you?** _____

11. **Please list names and ages of all children / step-children:**

12. **My general health is (check one):** Good Fair Poor

13. **I have the following health problems (check all that apply):**

- Stomach Diabetes Back Heart Headaches / Migraines Liver
- High Blood Pressure Sleeping Difficulties Other: _____

14. **I have or have taken the following medications in the past six months:**

_____ for _____
_____ for _____
_____ for _____

15. **Over the past month, I have felt (check all that apply):**

- Nervous Sad Depressed Angry Content Apathetic Happy
- Excited Tired Other: _____

16. **Today I feel:** _____

17. **I am interested in the following types of counseling (check all that apply):**

- Individual Family Couples Group Substance Abuse Parenting
- Anger Management Values Clarification Hypnotherapy Domestic Violence
- Women's Fertility Program PTSD / Military Individual / Family Grief counseling
- Adolescent Substance Abuse Program Building Awareness Stress / Anxiety
- Child / Adolescent Behavioral Development Workplace Diversity

18. **I would prefer my counseling to be:** In - person Phone Video

19. **I consider the following to be supports at this time in my life (check all that apply):**

- Family Friends Spouse Children Faith Job Sports Health
- Living Situation Finances Hobbies Other: _____

20. What are your major stressors and how do you handle them?:

21. What is your relationship like with your parents?:

22. Family history of drug / alcohol abuse:

23. Current issue bringing you to counseling:

24. Recent symptoms / impairments experienced:

25. How long have you been dealing with this issue:

26. Describe your mood over the last two weeks:

27. Have you ever had thoughts or feelings of hurting yourself or others? Yes No

If yes, who? _____

28. Mental health history (history of depression, past medication(s), etc.)

29. Past / Current Drug / Alcohol Use:

30. Have you ever been hospitalized for a mental health or substance abuse issue?

Yes No If yes, when? _____

31. Have you had a personal history of physical / emotional / sexual abuse?

Yes No If yes, please describe

32. Growing up, did you witness any family history of alcohol / drug abuse, violence or sexual abuse? Yes No If yes, please describe

33. Have you ever been in counseling previously? Yes No Please give a brief history:

Signature

Date

Atlanta Family

C O U N S E L I N G

INFORMED CONSENT

Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feelings of anxiety, depression, loneliness, or helplessness may also occur.

The benefits from psychotherapy may be that you will be better able to handle or cope with family or other social relationships, thus experiencing more satisfaction from those relationships. Another possible benefit may be a better understanding of your personal goals and values; this may lead to greater maturity and growth as a person.

You should know that your therapist is not a physician and cannot prescribe or provide you with any drugs or medication, or perform any medical procedures. If medical treatment is indicated, the therapist can recommend a physician for you.

If you wish to receive psychotherapy from _____, please sign your name below.

Signature

Date

INFORMED CONSENT REGARDING PATIENTS' RIGHTS AND RESPONSIBILITIES

A. You have the right to:

- a. To receive information about your rights and to know what action to take if you believe your rights have been violated.
- b. To have contact with your attorney about legal problems provided it does not conflict with your treatment process.
- c. To remove yourself from treatment at any time.
- d. To confidentiality, to not be photographed or recorded unless you agree in writing.
- e. To receive a certificate of completion at the end of successful programming when fees are paid in full.
- f. To request the opinion of a consultant, of either your choice or the staff's choice, at your expense, or to request staff review of your treatment plan.
- g. To know the exact nature of the care and treatment that you will receive while at Atlanta Family Counseling Center, Inc., as well as alternative treatment procedures that are available.
- h. To know the cost of treatment and your treatment staff, and to be informed of any changes.
- i. To be oriented to your program and your treatment staff, and to be informed of any changes.
- j. To be fully informed of the rules and regulations of the facility regarding patient conduct.

B. You are responsible:

- a. For the confidentiality of this program, the other patients, and staffs' rights to privacy.
- b. To attend regularly and to participate actively in treatment planning and treatment activities.
- c. To give 24-hour advance notice of appointment changes, otherwise a \$50 rescheduling fee will be charged. Overdue accounts may be sent to a collection agency.
- d. For the cost of your treatment not covered by insurance.
- e. For not breaking the law, deliberately hurting other persons, or destroying or stealing.
- f. To seek medical care if needed. Atlanta Family Counseling Center, Inc. staff does not prescribe medication.

C. Notice of Privacy Practices: Atlanta Family Counseling Center, Inc. has always placed value on the protection of your private information. Now, Federal Regulations, as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), are in effect. As a result, we are making further attempts to ensure confidentiality of your information. These regulations apply to a vast number of health providers, and Atlanta Family Counseling Center Inc. may be governed by them. As a result, your record may be protected under certain rules. There is no required action on your part as a result of these regulations, except for your signature indicating that you have read or received a copy of this notice.

This notice describes how we use and disclose your protected health information. It sets out legal obligations concerning your information and specifically protects information that is individually identifiable health information or health related payment information.

D. Our Responsibilities: We are responsible by law to maintain the privacy of your protected information and are obligated to provide you with a copy of this notice. We reserve the right to make changes in our confidentiality provisions. Should any changes be made, a notice will be posted. Your health related information is contained within an individually marked file and is kept in a secure location. Access to this information is limited to employed staff members. We will set office practices in place that will aid in ensuring that information about you is not improperly released. Your treatment staff are either licensed in the State of Georgia or are supervised by staff who are licensed.

E. Possible Disclosures of Your Information

- a. **Audit Activities:** Information may be disclosed to legally authorized agencies who audit or license our facility.
- b. **Abuse & Neglect:** We may disclose protected health information to government authorities who are authorized to receive reports of abuse, neglect, or violence.
- c. **Legal Proceedings:** We may disclose protected health information to judicial or administrative officers of the court in response to a subpoena or a court order.
- d. **Law Enforcement:** Under certain specified legal conditions, disclosure of information may be made to law enforcement officials.
- e. **Coroners/Medical Examiners:** Information may be disclosed to coroners or other medical examiners for the purposes of determining the identity of a deceased person.
- f. **Threat to Safety:** Consistent with Federal and State laws, we may disclose information if it is believed that disclosure is necessary to prevent or lessen an imminent threat to the health or safety of another person. For emergencies during non-work hours or if our staff are unavailable, please call 911.

- g. Worker's Compensation: Information may be disclosed should it be necessary to comply with Workers Compensation Law.
- h. Disclosures to you: You may request a change in your records if you believe that incomplete or inaccurate information is contained therein; request an Information Access/Change Form. We are not required to agree with you or necessarily make those changes. You may appeal a denial of change of record or a denial of access to information to the Compliance Project Leader which will assign it for further review by a HIPAA Assessment Team Member.

We are required to disclose some of your protected health information when you request access. The regulations authorize a \$20 administrative fee to be charged for each request. This fee will cover the administrative review of clinical issues, secretarial time involved with working with your file, and staff time to review the information in person with you. In addition, 75 cents per page (for 1 - 20 pages) or 65 cents (for 21 - 100 pages) will be assessed. There are exceptions to your receiving information about you from your file such as when civil or criminal actions are pending and involve the information contained in your file, or if the release of information would be harmful to you or to others. If the fees for your treatment services are not currently paid in full, services may no longer be provided to you, and/or access or copies of your file information will not be provided until your balance and fees associated with your treatment and review and possible copying charges are paid. Under the regulations, we have 30 days after your written request to provide you with the information. You may request an information access/change form from the office manager.

F. Complaints: For most complaints about your treatment, you should contact your counselor or the Director of your office. If you believe that we have violated your privacy rights, you may request a Privacy Complaint Form from the office manager which should be returned to: Project Leader, HIPAA Assessment Team, Atlanta Family Counseling Center, Inc., 190 Camden Hill Road, Suite A, Lawrenceville, Ga 30046.

You may also file a complaint regarding privacy with the Secretary of the U.S. Department of Health and Human Services. At this level, the complaint should include what you have done to remedy your concern with Atlanta Family Counseling Center directly by including your original complaint and Atlanta Family Counseling Center's response. Your complaint must be in writing, contain the name of the company against which you are complaining, and be filed within 180 days from the date which you became aware of the issue. You will not be retaliated against for making any complaint.

I, _____, acknowledge that I have read and understand the clients rights and responsibilities above, and I have read and/or have had available to me this notice of privacy practices.

Signature

Date

Atlanta Family

C O U N S E L I N G

INFORMED CONSENT

About our services.....

In order to provide you with our services, we need your consent in writing. This consent will enable us to treat you in a responsible manner and keep all information confidential to ensure your privacy in accordance with O.C.G.A. 37-7-2, 40-5-1, and 40-5-631.

I understand that the information and records are protected under federal regulations governing confidentiality and may not be disclosed without written consent, with the exception of a medical emergency, or if we feel you are about to harm yourself or others, or have committed a previously undisclosed crime which we are required to report to DFCS or other authorities, or as needed to Atlanta Family Counseling personnel.

I understand that if my counselor is an intern or is not fully licensed they are under the supervision of a licensed counselor. I understand that my information / case will be discussed with this supervisor. I understand that I have the right to name and contact information of this supervisor.

Psychotherapy may involve the risk of remembering unpleasant events and discussing sensitive issues. I understand that this process is intended to help me better cope with life situations and to experience growth as a person.

About your payment.....

Payment is expected at the time of service unless other arrangements have been made. Co-payments are required at the time of service if you are using insurance. You will be responsible for payment if we file insurance for you and the insurance carrier does not pay the full amount charged.

About your appointment....

A notice of 24 hours must be given if you are unable to keep your appointment. Otherwise, you will be charged a \$50 rescheduling fee.

I have read the above and understand that I will not receive services from Atlanta Family Counseling Center, Inc. without consent, and that I am responsible for all payments of services rendered by Atlanta Family Counseling Center, Inc.

Client Signature

Date

Witness Signature

Date

Atlanta Family

C O U N S E L I N G

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believe to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Atlanta Family Counseling, has put in place preventative measures to reduce the spread of COVID-19; however, Atlanta Family Counseling cannot guarantee that you or your child(ren) will not become infected with COVID-19.

Further, attending in-person appointments with Atlanta Family Counseling **could increase** your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my child(ren) may be exposed to or infected by COVID-19 by attending in-person appointments or groups with Atlanta Family Counseling and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Atlanta Family Counseling may result from the actions, omissions, or negligence of myself and others, including but not limited to Atlanta Family Counseling, their employees, volunteers, and other participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my child(ren) (including, but not limited to, personal injury, permanent disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my attendance or my child(ren)'s attendance at in person appointments or groups with Atlanta Family Counseling. On my behalf and/or on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless Atlanta Family Counseling, its employees, agents, and representatives of and from the claims including all liabilities, claims actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Atlanta Family Counseling, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person appointments or groups with Atlanta Family Counseling.

Print name of client

Signature of client/parent or legal guardian

Date

Atlanta Family

C O U N S E L I N G

Office Policies

Thank You for Choosing Atlanta Family Counseling

We realize that you have a choice in counseling providers and are pleased that you have chosen to seek care with us. The staff at Atlanta Family Counseling strives to exceed expectations in care and services in order to make your experience with us as comfortable and stress-free as possible. Please feel free to contact our office if you have any questions concerning our policies.

- Office Hours: We are open Monday-Thursday 9:00am-8:00pm, Friday 9:00am-2:00pm, Saturday 8:00am- 1:00pm for individual counseling services and other services. We offer a variety of group counseling sessions Monday-Thursday 6:00-9:00pm and on Saturday 8:00am-1:00pm.
- Appointments: Atlanta Family Counseling is committed to providing quality care to all our clients. To ensure this quality, we work by appointment only and encourage you to schedule times when you will be available and can make the set appointment. Our staff will make every effort to accommodate urgent requests. We understand that on occasion things do come up where you cannot make a scheduled appointment. If this happens we ask that you give us **24 hours notice** of a changed or cancelled appointment. If you “no-show” for an appointment or do not give us adequate notice we will charge you a **\$50* appointment fee**. If you are more than 15 minutes late to your scheduled appointment you will be considered a “no-show” and a fee will be applied to your account. If you have two appointment fees in a row you will not be allowed to schedule any future appointments and all future appointments will be canceled until those fees are paid in full. * Please be advised that the appointment fee is a client responsibility and will not be billed to insurance.
- Insurance: As a courtesy to our patients, Atlanta Family Counseling is happy to file insurance claims on your behalf. The insurance we work with include: Aetna, Cigna, BCBS, EAP, Tricare, Humana, and Military source one. Patients are responsible for co-pays at time of service. If applicable, you will be billed for any deductible or co-insurance amounts and/or fees for services not covered by your insurance (as stated in your insurance contract) by our billing department. If we are unable to verify your insurance coverage prior to scheduled appointment, patients will be responsible for fees associated with office visits at the time of service.
- Payment: Atlanta Family Counseling accepts cash, money orders, MasterCard, Visa, Discover and American Express. Should you become behind on your payments it is our choice to refuse services until your balance is paid or there is an effort to make payments. It is the policy of our office to make all reasonable attempts to collect outstanding patient balances should they accrue. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection. A \$20 collection fee will be added to all accounts sent to collection.
- Identification: For your protection and security, a photo identification will be requested at the time of services, as well as records release.

- Confidentiality of e-mail, cell phones, and faxes: It is very important to be aware that email and cell phone communication can be relatively easily accessed by unauthorized people and hence the privacy and confidentiality of such communication can be compromised. Please see our telemental consent for more information on the confidentiality of e-mail, cell phones, video sessions, and faxes.
- Bringing Friend and Family: During any form of counseling it is important for clients to notify their counselor ahead of time if a client would like to include a friend or family as part of the session. This will entail a release of information from the client to allow the person as a visitor into the session.
- Bringing children: Atlanta Family Counseling is not able to watch children while their parents are in counseling sessions. Children under the age of 9 are not allowed to be left unattended in our lobby and must be escorted to use the restroom. If you would like to speak with your child's counselor please make arrangements with their counselor for a session, phone call or email. Please make prior childcare arrangements.
- Food and Beverage: We do not allow food and beverage in the office or waiting area.
- Cigarettes: Atlanta Family Counseling is a smoke free environment. Please do not smoke within 30 feet of our office.
- Court Appearances: At times, our counselors are asked to testify in court. If this happens you will be billed for their time in court at the rate of \$500 an hour.

I have read and understand all of the Atlanta Family Counseling office policies. I agree to follow the policies and understand noncompliance can result in refusal of services.

Client Name (print) _____

Client Signature

Date

Atlanta Family

C O U N S E L I N G

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> Discover	<input type="checkbox"/> AMEX
	<input type="checkbox"/> Other			
Cardholder Name (as shown on card):				
Card Number:				
Expiration Date (mm/yy):				
CVV Number (on back of card): _____				
Cardholder ZIP Code (from credit card billing address):				

I, _____, authorize Atlanta Family Counseling to charge my credit card above for all session fees, cancellation fees and processing fees. I understand that my information will be saved on file for future transactions on my account.

Email used for VSee account and receipt: _____

Client Signature

Date