PERSONAL HISTORY

(Please Print)

Date: ____________

Name: ____

Current Address: ____

____

Permanent Address: ____

____

Home Phone: ____________ Work: ______________ County of Residence: __________

Date of Birth: ____________ Age: _____ Language spoken at home: ____________

In Case Of Emergency Contact: ____________________ Relationship: ______________

Address: ____

Weekly Salary: ____________________ Other Income: ____________________

Race: [ ] White, not Hispanic [ ] Black, not Hispanic

[ ] Hispanic [ ] Asian

[ ] Native American [ ] Other ____________________

Are you currently working? [ ] Yes [ ] No Occupation: ____________________

1. Name of Employer: ____
2. Employer's address: ____
3. How long have you been employed: __________________
4. If not employed, are you looking for employment? [ ] Yes [ ] No
5. Highest education level completed: __________
6. Are you an American citizen? [ ] Yes [ ] No Place of Birth: ____________________
7. If you are not a citizen, check one to the following:
   - [ ] Permanent Resident
   - [ ] Haitian Refugee
   - [ ] Cuban Refugee
   - [ ] Tourist
   - [ ] Refugee from other country: ____________________
8. Marital Status (check one)
   - [ ] Single
   - [ ] Divorced
   - [ ] Widow/Widower
   - [ ] Married, how long? __________
   - [ ] Separated, how long? ________

9. How many times have you been married? ______

10. How many persons are currently living with you? ______

11. Please list ages and genders of all your children/step-children:

____

12. My general health is: (Check one) [ ] Good [ ] Fair [ ] Poor

13. I have the following medical problems: (Check all that apply)

[ ] Stomach	[ ] Diabetes	[ ] Back
[ ] Heart	[ ] Headaches/Migraines	[ ] Liver
[ ] High Blood Pressure	[ ] Sleeping Difficulties	[ ] Other ______

14. I take/ or have taken the following medications in the last six months:

______ For ______

______ For ______

______ For ______

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

Nervous	Sad	Depressed	Angry	Content	Apathetic
Happy	Excited	Tired	Other ______		

16. Today, I feel ______.

17. I consider the following to be supports in my life at the present time: (Circle all that apply)

Family	Friends	Spouse	Children	Faith	Job	Sports
Living Situation	Finances	Health	Hobbies	Other ______		

18. What are your major stressors and how do you handle them? ______

____

____

19. How many times have you been arrested? ______

20. How many times have the police been called to you home without making an arrest? ______

21. How many of these arrests were alcohol or drug related? ______

22. How many times have you been arrested for other causes? ______

23. How old were you when you were arrested for the first time? ______

24. How old were you when you were arrested for the first time for alcohol or drugs? ______

25. List the approximate dates and charges of your arrests/citations/DFACS report/TPO: ______

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26. Have you ever received professional treatment for problems related to alcohol, drugs, domestic violence or other emotional problems? [ ] Yes [ ] No If yes, explain: __________

____

____

27. Have you ever had any thoughts of hurting yourself or others? ____________________

28. Have you had any recent thoughts of harming yourself or others? __________________

29. How old were you when you first drank alcohol/used drugs? _____

30. Have you ever thought you could have a problem with alcoholism/drug addiction? __________

31. The number of traffic tickets I received last year: ________

32. The number of traffic warnings I received last year: ______

33. I consider myself a ________ drinker/drug user.

[ ] Never [ ] Rare [ ] Occasional [ ] Social [ ] Moderate [ ] Frequent [ ] Heavy

34. In general, I drink/ use drugs:

[ ] 1-2 times/week [ ] 3-4 times/week [ ] 5-7 times/week [ ] Other ________________

35. Normally, I drink/use drugs:

[ ] At home [ ] At work [ ] Bar/Restaurant [ ] At Friends'/Relatives' [ ] Other____________

36. When I drink, I generally consume:

[ ] 1-2 drinks [ ] 3-6 drinks [ ] 6-9 drinks [ ] 9-12 drinks [ ] More than 12 drinks\

37. The most I have ever consumed on one occasion was: ______________________

38. Are you able to control your action when you drink/use drugs? ____________________

39. What drugs have you experimented with/ used/ abused? [ ] marijuana [ ] cocaine [ ] ecstasy

[ ] meth-amphetamines [ ] LSD [ ] heroine [ ] inhalants [ ] prescription medication

[ ] Other ____________________

40. When was the last time you drank/used drugs? ______________________________

41. Has anyone, including you, ever been concerned about your use of alcohol or drugs? ________

42. I was arrested/received a ticket (date): ______________ at (location)________________.

If applicable, the breathalyzer registered ________%

or [ ] Not administered or [ ] Refused.

43. Please describe what happened the day you were arrested/ticketed and/or what you were accused of and/or what charges you received. Date:____________ Location:____________________

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44. How long are you serving probation or under the supervision of the court/DFCS/ etc.?_______

45. If you are here for Domestic Violence or Anger Management, please complete the following information regarding the named victim of your case.

Name ______________________________ Relation to you ________________

Address ____________________________ Home phone ________________

__________________________________ Work phone ________________

__________________________________ Cell phone ________________

SELF EVALUATION (Please answer Yes or No)

1. Do you ever drink alcoholic beverages/use drugs shortly after waking? ______
2. Do you drink/use drugs heavily when you are alone? ______
3. Do you ever lose time from work because of drinking/using drugs? ______
4. Do you get hangovers? ______
5. Do you care less now about getting ahead than you used to? ______
6. Do you drink/use drugs to gain confidence? ______
7. Has your sexual potency (ability to perform) suffered since you have been drinking/using drugs? ______
8. Are you harder to get along with since drinking/using drugs? ______
9. Do you worry about drinking/using drugs? ______
10. Has your drinking/drug use ever caused problems for you at work? ______
11. Does your spouse/parents, etc., ever complain that the money you spend on drinking/drugs could be put to better use? ______
12. Do you drink/use drugs at the same time every day? ______
13. Has your drinking/drug use interfered with your making more money? ______
14. Have you ever had a hard time remembering all of or parts of what you said or did while drinking/using drugs? ______
15. Have your problems ever caused you to drink/use drugs more than usual? ______
16. Do you ever try to hide your drinking/drug use? ______
17. Do you ever feel guilty about your drinking/drug use? ______
18. Do you ever feel guilty about your drinking/using drugs when your friends say that you have had enough? ______
19. Have you ever though that you were drinking/using drugs too much and tried to quit or decrease your drinking/drug use? ______
20. Did you ever think that by changing jobs or moving to a new town you could reduce your drinking/drug use? ______
21. Do you try to avoid certain people when drinking/using drugs? ______
22. Have you ever had the shakes the day after drinking/using drugs? ______
23. Have you ever had a drink/drug to quiet the shakes ? ______

24. Have you ever had a prior alcohol/drug arrest? ______

25. Do you ever stay high for two or more days in a row? ______

26. Are you ever so depressed that you feel that life is not worth living? ______

27. Do you ever drink/use drugs the next day to cure a hangover or have a "pick me up?" ______

28. Do you drink/use drugs more than usual when you are disappointed, worried, frustrated, or angry? ______

29. Do you drink/use drugs to get over feeling shy or for courage? ______

30. Have you ever heard or seen things that were not real during or after drinking/using drugs? ______

31. Has anyone ever criticized you about your drinking/drug use habits? ______

32. Do you occasionally get drunk/use drugs without intending to? ______

33. Is you drinking/drug use hurting your family in any way? ______

34. Do you have a reason when you get drunk or use drugs? ______

35. Do you skip meals sometimes when you are drinking/using drugs? ______

36. Do you get the shakes when you do not drink/use drugs? ______

37. Is drinking/using drugs hurting your reputation? ______

38. Have you had many problems due to your drinking/drug use? ______

39. Do you drink/use drugs to relax or to help you get to sleep? ______

40. Have you ever had a physical fight when drinking/using drugs? ______

41. Has drinking/using drugs ever caused you to have problems with the one you love? ______

42. Have you ever gotten into trouble at work due to drinking/using drugs? ______

43. Do you ever drink/use drugs before noon? ______

44. Have you ever been told that you should quit drinking/using drugs by a doctor? ______

45. Have you ever been told that you have liver trouble by a doctor? ______

46. Have you ever attended a meeting of Alcoholics/Narcotics Anonymous? ______

47. Have you ever been to a hospital or clinic because of your drinking/drug use? ______

48. Have you ever had a serious discussion with someone about your drinking/drug use? ______

49. Have you ever wished you could give up alcohol/drugs completely? ______

50. Do you feel that you cannot give up alcohol/drugs? ______

ATLANTA FAMILY COUNSELING CENTER, INC.
INFORMED CONSENT REGARDING PATIENTS' RIGHTS AND RESPONSIBILITIES

A. You have the right to:
1. To receive information about your rights and to know what action to take if you believe your rights have been violated.
2. To have contact with your attorney about legal problems, provided it does not conflict with your treatment process.
3. To remove yourself from treatment at any time.
4. To confidentiality, to not be photographed or recorded unless you agree in writing.
5. To receive a certificate of completion at the end of successful programming when fees are paid in full.
6. 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.
7. 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.
8. To know the cost of treatment and the amount of any reimbursement on your behalf.
9. To be oriented to your program and your treatment staff, and to be informed of any changes.
10. To be fully informed of the rules and regulations of the facility regarding patient conduct.

B. You are responsible:
1. For the confidentiality of this program, the other patients, and staffs' rights to privacy.
2. To attend regularly and to participate actively in treatment planning and treatment activities.
3. To give 24-hour advance notice of appointment changes, otherwise a $25.00 rescheduling fee will be charged. Overdue accounts may be sent to a collection agency.
4. For the cost of your treatment not covered by insurance. There is a $25.00 fee for returned checks.
5. For not breaking the law, deliberately hurting other persons, or destroying or stealing.
6. To seek medical care if needed. Atlanta Family Counseling Center staff do 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, 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 required 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

(The following are some of the ways information about you might be released.)

1. Audit Activities: Information may be disclosed to legally authorized agencies who audit or license our facility.
2. Abuse & Neglect: We may disclose protected health information to government authorities who are authorized to receive reports of abuse, neglect, or violence.
3. 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.
4. Law Enforcement: Under certain specified legal conditions, disclosure of information may be made to law

enforcement officials.

5. Coroners/Medical Examiners: Information may be disclosed to coroners or other medical examiners for the purposes of determining the identity of a deceased person.
6. 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.
7. Worker's Compensation: Information may be disclosed should it be necessary to comply with Worker's Compensation Laws.
8. 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 $20.00 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 per page (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 30045.

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 or should have been aware of the issue. You will not be retaliated against for making any complaint.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE CLIENT'S RIGHTS AND RESPONSIBILITIES ABOVE, AND I HAVE READ AND/OR HAVE HAD MADE AVAILABLE TO ME THIS NOTICE OF PRIVACY PRACTICES:

__________________________________ ____________________

Client's Signature Date

ATLANTA FAMILY COUNSELING CENTER, INC.
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 the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and may not be disclosed without my written consent, with the exception of 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 DFACS or other authorities.

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-payment is required at the time of service if you are using insurance. You will be responsible for payment if we are filing 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 $25.00 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: _____________________