



3905 Johns Creek Court, Suite 260, Suwanee, GA 30024
(770) 753-0350 office (770) 497-9536 fax

Paraclete Counseling Center, Inc. offers biblically sound, psychologically competent professional counseling for individuals, couples, families and groups. Topical seminars and workshops, and consultations are also available.

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order for us to work most effectively together, I ask that you carefully read the information below. If you have any questions regarding the following information, please discuss these with me during your first session.

All counselors operate from some particular moral basis, which may or may not come from a religious perspective. We want to inform you that all the counselors in this office operate from a Judeo-Christian point of view. If you do not wish that to be included as a part of your counseling, please tell your therapist during your first session.

BENEFITS AND RISKS OF THERAPY:

There are some risks as well as many benefits with therapy. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. Sometimes a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives.

While you consider these risks, you should know also that scientists in hundreds of well-designed research studies have shown the benefits of therapy. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved.

CONFIDENTIALITY:

All information shared between counselor and client is confidential and will not be revealed unless required by law in such cases of suspected child abuse or threats of physical harm to self or others.

There are two situations in which I might talk about your case with another therapist. When I am out of the office or am not "on call", another therapist in this office will be available to you in emergencies. Therefore, this therapist needs to know about you. Generally, I will tell this therapist only what he or she needs to know about you to help you in an emergency.

Second, in order to give high quality treatment, I sometimes consult with other professionals about my clients. The same rules and laws that I am bound by also bind these professionals in order to protect your confidentiality.

PAYMENTS AND BILLING:

Therapy Sessions: Most therapy sessions last 50 minutes. If you require a longer or shorter session, it will be prorated based on your fee. Any client who has a balance of fees for more than two sessions will be unable to continue therapy until your payment is made. Individual exceptions can be made through your individual therapist. If you are unable to pay these fees, please talk to your therapist about this to make other arrangements. Please remember that final payment of your bill is your responsibility NOT your insurance company. In the event that we are unable to collect fees owed by you, we reserve the right to use an outside collection agency to work on our behalf to collect overdue balances.

Initial Session	\$120
Family/Couples	\$100
Individuals	\$100
Addiction Assessment	\$200
(Initial Session, Testing, Reports & Phone Interview with significant other)	
Interventions	\$100 per hour

Cancellation of Appointment: If you must cancel your appointment, please call the office and leave a message on your therapist's voicemail, if no one is able to take your call. **You must cancel at least 24 hours in advance of your scheduled appointment.** If you do not cancel your appointment 24 hours in advance, you will be charged our standard fee, not your co-pay. Insurance does not cover late cancellations or no shows. Exceptions will be made in case of illness or other emergency. Your cooperation in this matter is greatly appreciated.

Telephone Consultations: I understand that at times telephone consultations are necessary. If a conversation last over 10 minutes, please see the fee breakdown below.

<u>10-20 minutes</u>	<u>20-30 minutes</u>	<u>30-40 minutes</u>
\$25	\$35	\$45 and up

Court/Legal Testimony: As a general rule, the counselors in this center do not give court testimony. If you believe that court testimony may be necessary, please discuss this with your counselor in your first session.

Reports: I will not charge you for my time spent making simple reports to your insurance company. However, any reports needed for other professionals, including but not limited to lawyers, courts, other medical doctors, and school officials, will be charged a fee, please see the fee breakdown below.

<u>20-30 minutes</u>	<u>30-40 minutes</u>	<u>40-50 minutes</u>
\$35	\$45	\$55

Testing: At times I may find it necessary to have you complete an assessment to help better evaluate your situation. Some of these cases include but are not limited to depression, anxiety, marital therapy, addiction, etc. These assessments will be discussed with you prior to that time and fees will be discussed then. Assessments range in price from \$10-\$90.

Returned Checks: If your check is returned with Non Sufficient Funds, you will be assessed a \$20 fee.

IN CASE OF EMERGENCY:

In the event you have an emergency, please dial the office at 770-753-0350 and choose option 6 to leave a message for the on-call therapist. If you cannot wait for the therapist to return your call, please dial 911 or go to your local emergency room.

I have read and understand the conditions and information above and agree to these conditions.

Signature _____ Date _____

IMPORTANT EXTENSIONS:

New Clients	Option 2
Lisa Poore	102
Jennifer Stuckert	103
Troy Snyder	104
Pat Caffrey	105
Elizabeth (Libby) Balch	106
Phillips P. Hwang	107
Mary Ann Woodward	108
Kim Hart/Operator	101 or 0
Directions to Office	Option 4
Office Address & Fax #	Option 5
Emergency on-call therapist	Option 6

A copy of this form will be kept in your confidential file. If you wish to have a copy for your records, please request one.

Confidentiality and Managed Care

Your managed care plan (MCP) chosen by your employer sets limits on both you and your therapist. If you choose to access therapy through your MCP, you need to be aware that the plan will be involved in direct clinical management of your case. I will be required to give extensive and sensitive information about you and your case to the MCP. This information is used by the plan for determining benefits, which they allocate at their own discretion. This impacts your right of confidentiality, and it is possible that your information will be put into a computer system that could be accessed by anyone. The MCP will decide how many sessions I can provide to you and can even refuse to allow me to treat you. It can refuse to pay for *any* of your treatment, or may pay only a very small part of its cost. Finally, it can limit the kinds of treatments I can provide to you.

Even if it does give the “go-ahead” to treatment, the MCP may put limits on the number of times we can meet. Your insurance policy probably has a maximum number of appointments allowed for therapy, but the MCP does not have to let you use all of those appointments. Also, it may not agree to more sessions even if I believe we need more to fully relieve your problems, or even if I think that undertreating your problems may prolong your pain or lead to backsliding. If the MCP denies payment before either of us is satisfied about our progress, we may also need to consider other treatment choices, which may not be the ones we would prefer.

We can appeal the MCP’s decisions on payment and number of sessions, but we can only do so within the MCP itself. We cannot appeal to other professionals, to your employer, or through the courts without great effort. You should know that my contract or your employer’s contract with a particular MCP may prevent us from taking actions against it if things go badly because of its decisions.

If after reading this and discussing it with me, you are concerned with these issues, you have the choice of paying me directly and not using your health insurance. This will create no record outside of my files. Direct payment provides you with confidentiality.

I have read and understood the issues described above and willingly enter treatment accepting these limits. I give my therapist permission to submit information in order to secure payment for the mental health services to be provided to me.

Signature of client

Date

revised 7/2007



This form will enable us to gain a quicker understanding of you and it will become a part of your confidential file. Please answer each question as completely as possible. If you are a couple, please fill out two forms, one for each person.

Date _____

PART I: CLIENT

Name _____ Age _____ Sex _____
 First Middle Last

Address _____

City State Zip

Home Phone _____ Work Phone _____

Pager _____ Cell Phone _____

Date of birth _____ SS# _____

Marital Status: Single _____ Married _____ (# of years _____) Divorced _____

(How long? _____) Separated _____

Occupation _____ Total hours/week _____

Employer (or school) _____ Full-time Part-time

Address of employer _____

Primary Care Physician (PCP) _____

Address _____ Phone _____

Please list any over-the-counter medicines or prescribed medicines you are taking currently (herbs, supplements, etc.), including the dosages _____

Family member to notify in case of emergency _____

Emergency contact phone number _____

Who gave you my name? _____

May I have your permission to thank this person for your referral? Yes No

Would you like to receive information regarding upcoming events and groups offered by Paraclete? (Email) _____

Do you expect to be involved in any legal action where your counselor's documentation or testimony will be required? Please explain. _____

Religious Affiliation _____ Church _____

Active _____ Inactive _____

PART II: INFORMATION ON SPOUSE AND CHILDREN

Spouse's Name _____ Birthdate _____ SS# _____

Employer of Spouse _____

Address of Employer _____

Medications spouse is currently taking _____

Names and ages of children _____

Concern's Check List

<input type="checkbox"/> Anger	<input type="checkbox"/> Depression	<input type="checkbox"/> Education	<input type="checkbox"/> Eating difficulties
<input type="checkbox"/> Fearfulness	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Financial problems	<input type="checkbox"/> Marital problems
<input type="checkbox"/> Physical problems	<input type="checkbox"/> Social relationships	<input type="checkbox"/> Problems with children	<input type="checkbox"/> Abuse
<input type="checkbox"/> Problem with parents	<input type="checkbox"/> Spiritual concerns	<input type="checkbox"/> Sexual concerns	<input type="checkbox"/> Thoughts of suicide
<input type="checkbox"/> Trouble making decisions	<input type="checkbox"/> Unhappy most of the time	<input type="checkbox"/> Use of alcohol	<input type="checkbox"/> Use of other drugs
<input type="checkbox"/> Work	<input type="checkbox"/> Worry	<input type="checkbox"/> Other (Specify) _____	

PART III: FINANCIAL INFORMATION SHEET

If you have any financial questions or concerns about your fee, please talk to your therapist. Fees or co-pays are due at time of service. You may use cash, check, debit card, Visa, MasterCard or Discover.

Total gross family income _____ # of dependents _____

Who is financially responsible for these fees? _____

Do you have insurance? _____

Is your therapist an in-network provider for your insurance company? _Yes _No _I don't know

If your therapist is in your network, we will file all claims. If your therapist is out-of-network, we will file claims on your behalf **only if you have out-of-network benefits.**

ALL BLUE CROSS/BLUE SHIELD CLIENTS MUST FILE THEIR OWN CLAIMS—THEY WILL NOT PAY US AT ALL.

Primary Insurance Company _____

Address _____

Phone Number of Insurance Company _____

Policy # _____ Group # _____

Insured's Name _____ Insured's SS# _____

Insured's Date of Birth _____

Insured's Employer _____

I, the undersigned, do authorize the release of any medical information necessary to process claims. I hereby assign payments directly to Paraclete Counseling Center and the supervisors thereof of the benefits as well as major medical benefits herein specified, and otherwise payable to me under the terms of my insurance. I understand that I am financially responsible to the clinician for charges not covered by this agreement. I hereby authorize photocopies of this form to be as valid as the original. Signed this _____ day of _____, 20____; in the city of _____, situated in _____ county, state of Georgia.

Signed _____ **Date** _____

Psychosocial Assessment

Name: _____ Date: _____

Age: _____ Sex: _____ Therapist: _____

Directions: Please answer the following questions as fully as possible.

Problem Assessment

Present Problem-Precipitating Stressors "In the recent months, I have worried a lot about": (Please circle all that apply)

Marital issues Health issues Job issues Financial issues

Parent/child issues Issues of past (guilt, abuse, neglect, family of origin etc.)

Other _____

Symptoms (Please circle all that apply)

Change in sleep pattern Decreased concentration Change in appetite

Increased anxiety Decreased energy Suicidal feelings

Decreased motivation Other _____

Suicidal/Homicidal Ideation

Have you ever attempted to commit suicide or homicide in the past? _____

If yes, how? _____

Is there a history of suicide in your nuclear and/or extended family? _____

Have you ever inflicted burns or wounds to yourself? _____

Are you presently suicidal/homicidal? _____

Recent Losses (Please circle all that apply)

Family Health Disruption in lifestyle Job Significant other

Other _____

Psychiatric History

Please list any previous outpatient counseling experiences.

Place _____ Reason _____

Length of time _____ Dates _____

Place _____ Reason _____

Length of time _____ Dates _____

Have you ever been admitted to the hospital for mental health or addiction issues? _____

Place _____ Reason _____

Length of time _____ Dates _____

Name of current psychiatrist _____

List all medications you have taken *in the past* for anxiety, depression, and/or sleep

Medical Information

Describe any current medical condition _____

Are you currently on any medication _____ Please list the name of the medication, the dosage, the frequency and the prescribing physician _____

Are you currently taking any herbs? If yes, please list them _____

Has it been more than a year since your last physical exam-including blood test? _____

Have you ever had an abortion? _____

Do you have any allergies? _____

Please list any previous health problems, operative procedures, and medical hospitalization _____

Substance Abuse History

Describe your current usage, or usage within the past year of alcohol, caffeine, tobacco, pornography, gambling, and prescription pain medication (Please list the substance, the amount, the frequency, the age of 1st use, the age regular use started, and the date of last use). _____

Have you experienced a recent increase in the use of alcohol and/or other substances? _____

Do you see your current usage as a problem? _____

Please describe any previous experience with drugs or alcohol _____

Describe any significant family history of substance abuse _____

Nutrition

Have your eating habits changed recently? Yes No If yes, please describe _____

Has your weight fluctuated more than +/- 10lbs. over the previous year? Yes No

Do you often eat out of depression, boredom, and anger? Yes No If yes, please

describe_____

Do you ever self-induce vomiting? Yes No

How do you feel about eating with others in a group? _____

Do you ever binge eat or feel your eating is out of control? Yes No If yes, please

describe_____

If you use laxatives, water pills, or diet medications, how often do you use them? _____

Legal History (Please explain all that apply)

Charges as a minor_____

Charges presently _____

Arrests (How many) _____

Incarcerations (How many) _____

Parole _____

Convictions (How many) _____

Probation _____

Bankruptcy _____

Civil suits _____

Child custody problems _____

Developmental History

List members of your family that you grew up with and how you got along with each one

What was your birth order? ____ of ____ children Who primarily raised you? _____

How would you describe your childhood? Traumatic Painful Uneventful

What were you like as a child (include friends, school, hobbies, and personality)? _____

Were there any unusual or traumatic experiences for you as a child? (Please list the age that it occurred and the event that occurred)

What is your sexual orientation? Heterosexual Homosexual Bisexual

Support System

Who can you count on for support?

- | | | | | |
|--------------------|-----------|----------------|--------------|-----------------|
| Parents | Spouse | Siblings | Employer | Church |
| Pastor | Therapist | Neighbor | Close Friend | Self-help Group |
| Community Services | Co-Worker | Medical Doctor | | |

Who are you currently living with? _____

Financial Situation

Describe briefly your financial situation _____

Marital History (if applicable)

What was the date of your current marriage? _____ Name and age of spouse

Previous marriage? Yes No If yes, date of divorce _____

Any children from this marriage? _____

What is your perception of your current marriage (include communication patterns, problems, sexual relations) _____

Please list that name, ages and the custodial parent of each of your children. How do you get along with each one? _____

Religious/Cultural Factors

Please list any issues that are important or may have affected you in regard to religion or ethnic/cultural background _____

What is your religious background? _____

Do you currently attend church, synagogue or mosque? Yes No If yes, please list where you attend. _____

Work History

Describe your current job/career _____

Would you enjoy doing this job on a long-term basis? _____

If you could have any job/career, what would you choose? _____

Why would you choose this? _____

How do you deal with authority figures? _____

Describe your relationship with co-workers _____

Describe your job performance _____

Have you ever been fired? Yes No If yes, explain _____

How many jobs have you held within the previous five years? _____

Were you ever in the military? _____

Educational History

Highest level achieved? _____

What type of grades did you make? _____

Are you currently in school? Yes No If yes, what level? _____

Family

Would it be beneficial for any members of your family to be involved in your treatment?

Yes No If yes, explain _____

Is there anything else you feel that we need to know about you? Yes No If yes,

please explain _____
