



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>15 minutes</u>	<u>20-30 minutes</u>	<u>35-50 minutes</u>
\$25	\$50	\$75 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>15-20 minutes</u>	<u>30-40 minutes</u>	<u>40-50 minutes</u>
\$25	\$50	\$75 and up

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 \$30 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
Mary Ann Woodward	103
Troy Snyder	104
Pat Caffrey	105
Elizabeth (Libby) Balch	106
Rich Oswald	107
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 5-2010

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? _____

Recent Losses (Please circle all that apply)

Family Health Disruption in lifestyle Job Significant other Other _____

Psychiatric History (Please list any previous inpatient and outpatient counseling and/or addiction treatment experiences)

Place	Dates	Length of Time	Inpatient or Outpatient	Reason

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 _____

Height _____ Weight _____

Please list the name of the medication, dosage, frequency, prescribing physician and the date started (or attach a list).

Medication/Supplement	Dosage	Frequency	Prescribing Physician	Start Date

Date of your last physical exam including blood test? _____

Have you ever had an abortion? _____

Do you have any allergies? _____, If so, list them _____

Please list any previous health problems, operations and medical hospitalizations:

Substance Abuse History

Describe your current usage or usage within the past year of the following:

	First Use	Last Use	Average Amount	Frequency of use
Alcohol				
Marijuana				
Caffeine				
Meth				
Cocaine				
Heroin				
Pain Medication				
Morphine				
Nicotine				
Pornography				
Gambling				
Other _____				

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

Do you see your current usage as a problem? _____

Is there a history of alcohol and substance abuse in your family? _____, If so, who? _____

Nutrition

Have your eating habits changed recently? Yes No

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

Do you ever self-induce vomiting? Yes No

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

Do you use laxatives, water pills, or diet medications? Yes No

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

Legal History (Please circle all that apply)

Charges as a minor Charges presently Arrests Incarcerations Parole Convictions
 Probation Bankruptcy Civil suit DUI Other _____

Developmental History

List members of your family that you grew up with

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)? _____

What is your sexual orientation? Heterosexual Homosexual Bisexual

Support System

Who can you count on for support? _____

Who are you currently living with? _____

Financial Situation

Describe briefly your financial situation _____

Marital History (if applicable)

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

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

Religious/Cultural Factors

What is your ethnic/cultural background? _____

What is your religious background? _____

Do you currently attend church, synagogue or mosque? Yes No ACTIVE INACTIVE

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? _____

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

Spouse's Name _____ Age _____ Birthdate _____

Children

Name	Age	Living with you (y/n)	Biological, Step, Adopted or Foster?	Custody

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 _____

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 cards, Visa, MasterCard or Discover.

PART A

Total gross family income _____ # of dependents _____

Who is financially responsible for these fees? _____

Do you have insurance? _____

If your therapist is a contracted provider with your insurance company, we will file all claims. If the therapist is **not** a contracted provider, we will verify whether you have out-of-network benefits. If you do, we will file for you; and you will be responsible for all deductibles and co-pays. If you do not, no claims will be filed; and you will be responsible for all fees at the time of service.

ALL BLUE CROSS/BLUE SHIELD CLIENTS MUST FILE THEIR OWN CLAIMS. BLUE CROSS/ BLUE SHIELD WILL ONLY REIMBURSE THE INSURED NOT NON-NETWORK PROVIDERS.

PART B

Is your therapist a part of your managed care plan? ___Yes ___No ___I Don't Know

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 _____