



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

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. Your therapist 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 will be provided to you and can even refuse to allow us to treat you. The MCP 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 we can provide to you.

Even if it does give the “go-ahead” to treatment, the MCP may put limits on the number of times you can meet with your therapist. 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 there is a need for more to fully relieve your problems or even if the therapist thinks that under treating your problems may prolong your pain or lead to backsliding. If the MCP denies payment before either you or your therapist are satisfied with your progress, other treatment choices may need to be considered, which may not be the ones preferred.

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 your therapist, you are concerned with these issues, you have the choice of paying Paraclete Counseling Center directly and not using your health insurance. This will create no record outside of office. 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

Who has legal custody? Mom _____ Dad _____ Joint _____ Other _____

Who has physical custody? Mom _____ Dad _____ Joint _____ Other _____

Stepparent's name _____ Birthdate _____

Address _____ Home phone _____

Employer _____ Work phone _____

Who gave you our name? _____

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

Religious Affiliation _____ Church _____

Parents Active _____ Inactive _____ Child Active _____ Inactive _____

Part III: Financial

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? _____

Is your therapist an in-network provider for your insurance company? Yes No 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 only if you have out-of-network benefits.

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 History

Part IV: Development

Please fill in any information you have on the areas listed below.

Prenatal medical illnesses and health care _____

Was the child premature? _____ Any birth complications or problems? _____

In the first few months of life, please list any problems in the following areas.

Any allergies? _____

Sleep patterns or problems _____

Personality _____

Does your child have any speech, hearing, or language difficulties? _____

Please describe any special classes that your child has attended or currently attends _____

Part V: Health

List any major childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures and other medical conditions. Please list the condition, age, and consequences _____

Part VI: Residences

1. Homes - please list all dates that the child has lived in different residences, including location, who they were living with, their reason for moving, and any problems.

2. Residential placements, institutional placements, or foster care - if applicable, please list dates that the child was placed in a home, the program and location, the reason for the placement, and any problems.

Part VII: Schools

Please list all of the schools the child has attended, including grades. Please list the current grade, school, and teacher.

Part VIII: Special skills or talents of child

List hobbies, sports, recreational interests, TV, and toy preferences, etc. _____

Part IX: Other

Is there anything else I should know that doesn't appear on this or any other forms, but might be important? _____

Symptom Checklist

Below you will find statements about your child and any symptoms he or she may be experiencing. Circle the number below the word that best describes your child's behavior during the last 3 months. Please write under the statement any additional information that you feel would be helpful.

Personal-Social

	Never	Sometimes	Often	Always
1. My child continually seeks attention.	0	1	2	3
2. I can see tension building up in my child.	0	1	2	3
3. My child explodes under stress.	0	1	2	3
4. My child has nervous habits, like pulling at his/her clothing, clearing his/her throat, sniffing his/her nose, etc.	0	1	2	3
5. My child cries easily.	0	1	2	3
6. My child sucks his/her thumb or finger.	0	1	2	3
7. My child is a worrier.	0	1	2	3
8. My child rocks back and forth.	0	1	2	3
9. My child shakes and trembles.	0	1	2	3
10. My child expresses many or unusual fears.	0	1	2	3
11. My child is angry.	0	1	2	3
12. My child is moody.	0	1	2	3

	Never	Sometimes	Often	Always
13. My child becomes overexcited easily.	0	1	2	3
14. My child is hyperactive and restless.	0	1	2	3
15. My child becomes hysterical, upset, or angry when things do not go his/her way.	0	1	2	3
16. My child seems sad.	0	1	2	3
17. My child has sleep problems.	0	1	2	3
18. My child has bad dreams.	0	1	2	3
19. My child walks or talks in his/her sleep. (underline one or both)	0	1	2	3
20. My child gets confused easily.	0	1	2	3
21. My child has trouble remembering things.	0	1	2	3
22. My child has difficulty concentrating for any length of time.	0	1	2	3
23. My child complains he/she never gets a fair share of things.	0	1	2	3
24. My child says people don't like him/her.	0	1	2	3

	Never	Sometimes	Often	Always
25. My child tends to be very selfish and self-centered.	0	1	2	3
26. My child is very shy.	0	1	2	3
27. My child is sensitive and has his/her feelings hurt easily.	0	1	2	3
28. My child avoids competition.	0	1	2	3
29. My child is a poor sport and a poor loser.	0	1	2	3
30. My child has trouble making friends.	0	1	2	3
31. My child seems to have little self-confidence.	0	1	2	3
32. My child cannot get along with my husband/wife.	0	1	2	3
33. We have family problems.	0	1	2	3
34. There is a lot of arguing and fighting in our house.	0	1	2	3
35. My child expresses concerns about something terrible or horrible happening to family members or himself/herself.	0	1	2	3
36. My child does not get along with his/her siblings.	0	1	2	3
37. My child expresses strong dislike for home and family.	0	1	2	3

	Never	Sometimes	Often	Always
38. One (or more) of my children has problems, also.	0	1	2	3
39. My child says strange things or asks unusual questions.	0	1	2	3
40. My child does strange or stupid things.	0	1	2	3
41. My child often says he/she wishes he/she were dead or away from it all.	0	1	2	3
42. My child has been physically or sexually abused.	0	1	2	3
43. My child often has small accidents or injuries.	0	1	2	3
Behavioral				
44. My child is a discipline problem at home.	0	1	2	3
45. My child is a discipline problem at school.	0	1	2	3
46. My child tells tall tales or lies.	0	1	2	3
47. My child often throws temper tantrums.	0	1	2	3
48. My child has attempted to seriously harm a person or animal.	0	1	2	3
49. My child manipulates situations to his/her own benefit.	0	1	2	3
50. My child does sexual things he/she shouldn't.	0	1	2	3
51. My child seems to welcome punishment.	0	1	2	3

	Never	Sometimes	Often	Always
52. My child disturbs other children by teasing, provoking fights, and interrupting others.	0	1	2	3
53. My child steals things.	0	1	2	3
54. I have to spank my child.	0	1	2	3
School				
57. My child voices an intense dislike of school.	0	1	2	3
58. My child does not seem to be learning, as he/she should.	0	1	2	3
59. The teachers complain about my child.	0	1	2	3
64. My child stares blankly into space and is unaware of his/her surroundings when doing so.	0	1	2	3
68. My child often complains of illnesses such as nausea, stomach pain or headaches.	0	1	2	3
69. My child sometimes has accidental bowel movements in his/her clothing.	0	1	2	3
70. My child has eating problems.	0	1	2	3
71. My child wets the bed.	0	1	2	3

Please circle YES or NO to the following statements as it pertains to your child.

Physical

60. My child's bowels do not move regularly. YES NO

61. My child is overweight or underweight. YES NO

(underline which one applies)

63. My child has had a major illness, operation
or accident (such as a fall or bump on the
head). If yes, please list _____

School

55. My child is in a special program at school. YES NO

56. My child may have a learning disability. YES NO

65. My child has a visual, hearing, or speech problem. YES NO

66. My child has allergies or asthma. YES NO

67. My child has a chronic illness or handicap. YES NO

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