

Confidential Client Information

Today's Date _____

Name _____
(Last Name, First Name Initial)

Date of Birth _____ Age _____

Home Phone _____ Work Phone _____

Other Phone _____

OK to Leave Messages at Which of the Above? _____

Home Address _____

City _____ State _____

Zip _____ How long at this address? _____

Social Security# _____

Driver's License # & State _____

E-mailAddress _____

Can we send you our monthly e-newsletter? YES, thanks NO, thanks (please circle)

Responsible Party (for minors) _____

Date of Birth _____ Age _____

Employer _____

Occupation _____

Employer's Address _____

Partner's / Spouse's Name _____

Partner's Date of Birth _____

Healing Psychotherapy Practices of Georgia, LLC

125 Townpark Dr., suite 300 Kennesaw, GA 30144 Tel: 404)553-1291

Partner's Employer _____

Partner's Occupation _____

Partner's Business

Address _____

Person to Contact in Case of Emergency _____

Relationship _____

Emergency Contact Home Phone _____

Work Phone _____ Other Phone _____

Primary Care Physician _____

Phone _____

Pharmacy _____

Phone _____

Who May We Thank For Referring You?

Healing Psychotherapy Practices of Georgia, LLC

1301 Shiloh Rd., suite 710 Kennesaw, GA 30144 Tel: 770) 792-0079

CLIENT AGREEMENT

Thank you for asking us to participate in your health care. The following are our policies and procedures. Please read them carefully, and ask any questions you may have before signing this agreement.

1. Phone calls: Calls are returned Monday through Friday, we attempt to return calls in a timely manner. Please leave your phone number with your message.

2. Emergencies: If you have an emergency and need to contact your therapist, please call our office. If your emergency cannot wait for a call back, please call 911 or go to your nearest Hospital Emergency Room.

3. Cancellation policy: If you fail to cancel a scheduled appointment, we cannot use this time for another client. Therefore, you will be billed for the entire cost of a missed appointment.

a. A full session fee is charged for missed appointments or no show cancellations with less than a **24 hour notice**. The full session fee will be added to the client's next session, if a credit card is not available.

b. If the client(s) do not show for the next session, a bill will be mailed directly to all clients who do not show up for a following appointment.

c. Clients using insurance: A fee of \$55 will be charged for missed appointments or no show cancellations with less than a **24 hour notice**, this may vary for EAP clients depending on their insurance provider.

d. Clients who are self pay: You will be charged the full amount of your session.

****Your therapist will discuss missed appointments due to illness or an emergency with the billing department, to see if a waiver is possible.**

4. Billing: The following billing policies apply:

a. Fees for sessions are due at the time of service. We accept cash, check, money order, and credit cards. There will be an additional \$10 fee for bounced checks.

b. In the event we are unable to collect on your account, be advised that uncollected fees may be turned over to the office's collection agency. Only necessary information will be released to them. Please be assured that we will make every effort to work with you before this happens.

c. The credit card on file is the card that will be used to collect on ALL outstanding debts and fees.

d. You will need to place a check or cash on file, if you do not want to use your credit card for missed appointments. It will be the amount of one session fee, if self pay, or \$55.00 if using insurance.

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CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Suicide/Homicide

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Legal

To respond to a subpoena from a court.

****Information that may be requested in any of the above limits includes: type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.**

Client Signature (Client's Parent/Guardian if under 18)

Today's Date

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CONSENT TO TREATMENT: By signing this Client Information and Confidentiality, and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me, and I understand that I may stop such treatment or services at any time.

Client Signature (Client's Parent/Guardian if under 18)

Today's Date

Therapist

Today's Date