Healing Psychotherapy Practices of Georgia, LLC
1301 Shiloh Rd., suite 710 Kennesaw, GA 30144 Tel: 770) 792-0079

Confidential Client Information and Agreement

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_____

E-mailAddress_____

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

IF CLIENT IS A MINOR:

Responsible Party (for minors)_____

Date of Birth_____Age_____

Employer/ Occupation_____

Partner's / Spouse's Name_____

Partner's Date of Birth _____

Employer/ Occupation _____

CLIENT EMERGENCY INFO:

Person to Contact in Case of Emergency _____

Relationship _____

Emergency Contact Phone Number _____

DOCTOR INFO:

Primary Care Physician_____

Phone_____

Psychiatrist_____

Phone_____

Who May We Thank For Referring You?

_____

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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:
A no show fee is charged for missed appointments or cancellations with less than a **24 hour notice**. **If you fail to cancel a scheduled appointment, we cannot use this time for another client who may need it. Therefore, you will be billed for the missed appointment reservation.**

a. Missed appointment fee: The fee for counseling appointments that are not cancelled within 24 hours is $70.00. This will be charged to the card on file or your cash or check will be deposited.

b. Clients who cannot be charged: Certain EAP's and insurance companies prevent us from charging a no show fee. In this case, a client who fails to keep their counseling reservation on more than one occasion may be referred to another counseling practice for ongoing support.

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 $20 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 fees and/or debts. If placing cash or check on file, **the amount is $70.00**.

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COMPLETION OF FORMS POLICY

An administrative fee is charged for the completion of all documents/ questionnaires presented by patients for completion by providers. (Please see Fee Schedule below.) These documents include but are not limited to disability insurance benefit forms, Family and Medical Leave Act (FMLA) forms, school forms, and medical reports. These fees are due prior to the completion of the forms.

Our priority is providing treatment to our patients, therefore, we ask that you give us a minimum of **7-10 business days** for completion of forms.

Note: Our providers do not do disability evaluations.

Fee Schedule:

If a document or letter takes the therapist longer than 15 minutes to complete, there will be a small fee for the creation and completion of the needed information.

One Page Form or Written Letter/Report:	$15
Multiple Page Form:	$30
Multiple Pages (beyond 3 pages)	$5 per additional page

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

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