Atlanta Family
COUNSELING

PERSONAL HISTORY

(Please Print)

Fecha: _____

Nombre: _____

Dirrecion presente: _____

_____

Dirrecion Permanente: _____

_____

Telephono: _____ Celluar: _____ Numero de Trabjao: _____

Preferente Contacto: [ ] Cell phone [ ] Home phone [ ] Text- Mobile carrier:_____ [ ] Email

Email Dirrecion:_____Condado de residencia: _____ Sexo: [ ] Masculino[ ] Feminio

Fecha de Naciemento: _____ Edad: _____ Número de la seguridad social _____

Idioma: _____

Contacto de Emergencia: _____ Relacion: _____

Dirrecion: _____ Telephono_____

Raza: [ ] White, not Hispanic [ ] Black, not Hispanic

[ ] Hispanic [ ] Asian

[ ] Native American [ ] Other _____

Etnia:_____

Trabajo? [Si [ ] No Occupacion _____

Salario: _____ Otro: _____

1. Nombre de Empleador: _____
2. Empledadro Dirrecion: _____
3. Duracion del empleo _____

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4. No es emledado, el tiempo en buscar de trabajo? [ ] Si [ ] No

5. Como se entero de la AFC?:_____

6. Ciudadano de Los Estados Unidos? [ ] Yes [ ] No Lugar de Nacimiento: _____

7. Nivel de Educaion Compledtado: _____

8. Estado Civil (check one)
   [ ] soltero [ ] casado/cuanto tiempo? _____
   [ ] divorcidado [ ] apartado/cuanto tiempo? _____
   [ ] viuda

9. Cuantos tiempos casado? _____

10. Cuantos personas vivar con usted? _____

11. Please list ages and genders of all your children/step-children:

    _____

12. Salud: (Check one) [ ] Bueno [ ] mediano [ ] pobre

13. Problemas medicos: (Check all that apply)

    [ ] estomago [ ] Diabetes [ ] espalda
    [ ] corazon [ ] Dolores de cabeza [ ] higado
    [ ] hypertension [ ] problemas dormir [ ] Otras _____

14. Yo tomo medicamentos para:

    _____ para _____

    _____para _____

    _____ para _____

    En el ultimo mes me he sentido:

    Nervioso Triste Deprimido Enojado Contenta Apathetic
    Feliez Excitado candado Otras _____

15. Siento hoy _____.

16. Interesado en los siguientes tipos de counseling:

    Individual Familia Groupp Abuso de sustanicas
    Gestion Enfado Valores HIpnoterapia Violencia Domestica
    Women's Fertility Program PTSD/Military Individual/Family Gestion Dolor
    Adolescent Substance Abuse Prevention Crianza de los hijos
    Ansiedad/Estres Gestion

17. Apoyo en mi vida:

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Familia Amigos Esposo/a Hijos Fe Trabjao

18. Como manejar el estres en su via? _____

_____

19. Relacion con sus padres?:_____
20. Familia historia de drugos abuso? _____
21. Problema actual hoy?: _____

_____

22. L:os sintomas?: _____

_____

23. Cuantos tiempos con esto problema? _____
24. La disposicion de animo hoy?: _____
25. Pensado en el sucido o homicide? [ ] Si [ ] No

Si, por favor descricipion : _____

26. Historial de salud mental (depression, medications etc_ _____

_____

_____

27. Pasado/Corriente/ Abuso de drugos o

alcohol:_____

_____

_____

28. Ha sido hospitalizado por problema de salud mental? _____

_____

29. Historia de abuso fiscio o sexual? _____ Si, por favor descripcion:

_____

_____

30. Usted es mira abusos durante la nino/a?

_____

31. Previo counseling? _____Si, por favor descripcion:

_____

_____ _____

Firma Fecha

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Informed Consent

Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feelings of anxiety, depression, loneliness, or helplessness may also occur.

The benefits from psychotherapy may be that you will be better able to handle or cope with family or other social relationships, thus experiencing more satisfaction from those relationships. Another possible benefit may be a better understanding of your personal goals and values; this may lead to greater maturity and growth as a person.

You should know that your therapist is not a physician and cannot prescribe or provide you with any drugs or medication, or perform any medical procedures. If medical treatment is indicated, the therapist can recommend a physician for you.

If you wish to receive psychotherapy from _____, please sign your name below.

_____ _____

Signature Date

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Office Policies

Thank you for choosing Atlanta Family Counseling.

We realize that you have a choice in counseling providers and are pleased that you have chosen to seek care with us. The staff at Atlanta Family Counseling strives to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible. Please feel free to contact our office if you have any questions concerning our policies. Please initial next to each of the following policies:

_____ Office Hours: We are open Monday – Thursday 9:00am-8:00pm* and Friday 9:00am-12:00pm for individual counseling sessions and other services. We offer a variety of group counseling sessions Monday-Thursday 6:00pm-9:00pm and on Saturday 8:00am-1:00pm. *Hours are subject to change and it is your responsibility to find out this information.

_____ Appointments: Atlanta Family Counseling is committed to providing quality care to all of our clients. To ensure this quality we work by appointment only and encourage you to schedule times when you will be available and can make the set appointment. Our staff will make every effort to accommodate urgent add on requests. We understand that on occasion things do come up where you can not make a scheduled appointment. If this happens we ask that you give us 24 hours notice of a changed or canceled appointment. If you 'no-show' an appointment or do not give us adequate notice we will charge you a $25* appointment fee. If you are more than 15 minutes late to your scheduled appointment you will be considered a 'no-show' and a fee will be added to your account. *Please be advised that the appointment fee is the clients' responsibility and will not be billed to insurance.

_____ Insurance: As a courtesy to our patients, Atlanta Family Counseling is happy to file insurance claims on your behalf. The major insurances we work with include: Aetna, Cigna, BCBS, EAP, Tricare, Humana, and some others. Patients are responsible for co-pays *at time of service*. If applicable, you will be billed for any deductible or co-insurance amounts, and/or fees for services not covered by your insurance (as stated in your insurance contract) by our billing department. If we are unable to verify insurance coverage prior to scheduled appointments, patients will be responsible for fees associated with office visits *at time of service.*

_____ Payments: Atlanta Family Counseling accepts cash, money orders, MasterCard, Visa, Discover, and American Express. Should you become behind in payments it is our choice to refuse services until your balance is paid or there is an effort to make payments. It is the policy of our office to make all reasonable attempts to collect outstanding patient balances' should they accrue. Following these attempts, accounts in poor standing will be outsourced to a third party for the purposes of collection. A $20 Collection fee will be added to all accounts sent to collections.

_____ Identification: For your protection and security, photo identification will be requested at the time of service, as well as records release.

_____ Confidentiality of E-mail, Cell Phone and Faxes: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. At the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices please let the office's staff know.

_____ Bringing Friends/Family: During any form of counseling it is important for clients to notify their counselor ahead of time if a client would like to include a friend or family as part of session. This will entail a release from the client to allow the person as a visitor into the session.

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_____ Bringing Children: Atlanta Family Counseling is not able to watch children while their parents are in a counseling session. Please make prior childcare arrangements.

_____ Pets: Atlanta Family Counseling may have therapy pets on the premises. If you are allergic or scared of any type of pet, please let the staff know. We do not allow outside pets in the office unless it is a certified therapy animal.

_____ Food & Beverages: We do not allow food or beverages in the office or waiting area without a lid.

_____ Cigarettes: Atlanta Family Counseling is a smoke free environment. Please do not smoke within 30 feet of our office.

_____ Court Appearances: At times our counselors are asked to testify in court. If this happens you will be billed for their time in court.

_____ Urine Drug Screens: All Urine Drug Screens are $30.00.

I have read and understand all of the Atlanta Family Counseling office policies. I agree to follow the policies and understand noncompliance can result in refusal of service.

Client Name (print) _____

Client Signature _____ Date _____

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Release of Information

NAME: _____ DOB_____

I, the above mentioned, authorize Atlanta Family Counseling Center, Inc. to release/obtain information to the facilities/persons listed below by mode of: Fax, Phone, Personal Conference, or Copies, that may be needed to treat me more effectively.

To: Facility/Person_____ Phone: _____

Address: _____

_____

Date of Service: _____

Information to be sent:

___ Results of psychological testing
___ MMPI profile
___ Medication
___ Diagnosis
___ Statement of Progress
___ School records
___ Other
___ Discharge Summary
___ Recommendation for current therapy
___ Domestic Violence Orientation
___ Anger Management Evaluation
___ Substance Abuse Evaluation
___ Psychosocial Evaluation

To be used for the purpose of: _____

_____

"This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42, CRF, Part II) prohibit you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose."
This authorization to release/receive information shall be effective for twelve months. You may terminate this authorization, however, at any time except to the extent that the program or person making the disclosure has already acted in reliance upon it.

I hereby release Atlanta Family Counseling Center, Inc. from all legal liability that might arise from the release of information requested. I consider a photocopy of this authorization to be as valid as the original.

_____ _____ _____ _____
Client Date Parent/Legal Guardian (relationship) Date

_____ _____