Atlanta Family
COUNSELING

PERSONAL HISTORY

(Please Print)

Date: _____

Name: _____

Current Address: _____

_____

Permanent Address: _____

_____

Home Phone: _____ Cell: _____ Work: _____

Preferred method of contact: [ ] Cell phone [ ] Home phone [ ] Text- Mobile carrier:_____ [ ] Email

Email Address:_____ County of Residence: _____ Gender: [ ] Male [ ] Female

Date of Birth: _____ Age: _____ Language spoken at home: _____

In Case Of Emergency Contact: _____ Relationship: _____

Address: _____ Phone _____

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

[ ] Hispanic [ ] Asian

[ ] Native American [ ] Other _____

Ethnicity:_____

Are you currently working? [ ] Yes [ ] No Occupation: _____

Weekly Salary: _____ Other Income: _____

1. Name of Employer: _____
2. Employer's address: _____
3. How long have you been employed: _____
4. If not employed, are you looking for employment? [ ] Yes [ ] No
5. How were you referred to us:_____

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6. Are you an American citizen? [ ] Yes [ ] No Place of Birth: _____

7. Highest education level completed: _____

8. Marital Status (check one)
   [ ] Single
   [ ] Divorced
   [ ] Widow/Widower
   [ ] Married, how long? _____
   [ ] Separated, how long? _____

9. How many times have you been married? _____

10. How many persons are currently living with you? _____

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

_____

12. My general health is: (Check one) [ ] Good [ ] Fair [ ] Poor

13. I have the following medical problems: (Check all that apply)

[ ] Stomach	[ ] Diabetes	[ ] Back
[ ] Heart	[ ] Headaches/Migraines	[ ] Liver
[ ] High Blood Pressure	[ ] Sleeping Difficulties	[ ] Other _____

14. I take/ or have taken the following medications in the last six months:

_____ For _____

_____ For _____

_____ For _____

15. Over the past month, I have felt: (Circle all that apply)

Nervous Sad Depressed Angry Content Apathetic
Happy Excited Tired Other _____

16. Today, I feel _____.

17. I am interested in the following types of counseling: (Circle all that apply)

Individual Marriage and Family Group Substance Abuse
Anger Management Values Clarification Hypnotherapy Domestic Violence
Women's Fertility Program PTSD/Military Individual/Family Grief Counseling
Adolescent Substance Abuse Prevention Parenting Bulling Awareness
Workplace Diversity/Ethics Training Adolescent /Child Behavioral Development
Telephone/Online (Skype) Counseling Stress /Anxiety Management

18. I consider the following to be supports in my life at the present time: (Circle all that apply)

Family Friends Spouse Children Faith Job Sports
Living Situation Finances Health Hobbies Other_____

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19. What are your major stressors and how do you handle them? _____

_____

20. Relationship with Parents: _____

21. Family history of Drug/alcohol abuse _____

22. Current issue bringing you to counseling: _____

_____

23. Recent symptoms or impairments experienced: _____

_____

24. How long have you been dealing with this issue? _____

25. Describe your mood over the past two weeks: _____

26. Have you ever had feelings/thoughts of hurting yourself or others? [ ] Yes [ ] No

If yes, Please describe: _____

27. Mental health history (history of depression, past medication(s) etc.) _____

_____

_____

28. Past/Current Drug/Alcohol use: _____

_____

_____

29. Have you ever been hospitalized for a mental health or substance abuse issue? _____

_____

30. Have you had and personal history of physical/emotional/sexual abuse? _____ If so please describe _____

_____

31. Growing up, did you witness any family history of alcohol/drug abuse, violence, or sexual abuse?

_____

32. Have you ever been in counseling previously? _____If so, please give a brief history:

_____

_____

_____ _____

Signature Date

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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 cannot 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.

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

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_____ 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 _____

ATLANTA FAMILY COUNSELING CENTER, INC.
INFORMED CONSENT REGARDING PATIENTS' RIGHTS AND RESPONSIBILITIES

A. You have the right to:

1. To receive information about your rights and to know what action to take if you believe your rights have been violated.
2. To have contact with your attorney about legal problems, provided it does not conflict with your treatment process.
3. To remove yourself from treatment at any time.
4. To confidentiality, to not be photographed or recorded unless you agree in writing.
5. To receive a certificate of completion at the end of successful programming when fees are paid in full.
6. To request the opinion of a consultant, of either your choice or the staff's choice, at your expense, or to request staff review of your treatment plan.
7. To know the exact nature of the care and treatment that you will receive while at Atlanta Family Counseling Center, Inc., as well as alternative treatment procedures that are available.
8. To know the cost of treatment and the amount of any reimbursement on your behalf.
9. To be oriented to your program and your treatment staff, and to be informed of any changes.
10. To be fully informed of the rules and regulations of the facility regarding patient conduct.

B. You are responsible:

1. For the confidentiality of this program, the other patients, and staffs' rights to privacy.
2. To attend regularly and to participate actively in treatment planning and treatment activities.
3. To give 24-hour advance notice of appointment changes, otherwise a $25.00 rescheduling fee will be charged. Overdue accounts may be sent to a collection agency.
4. For the cost of your treatment not covered by insurance. There is a $25.00 fee for returned checks.
5. For not breaking the law, deliberately hurting other persons, or destroying or stealing.
6. To seek medical care if needed. Atlanta Family Counseling Center staff do not prescribe medication.

C. Notice of Privacy Practices: Atlanta Family Counseling Center, Inc. has always placed value on the protection of your private information. Now, Federal Regulations, as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), are in effect. As a result, we are making further attempts to ensure confidentiality of your information. These regulations apply to a vast number of health providers, and Atlanta Family Counseling, Inc. may be governed by them. As a result, your record may be protected under certain rules. There is no required action on your part as a result of these regulations, except for your signature indicating that you have read or received a copy of this notice.

This notice describes how we use and disclose your protected health information. It sets out legal obligations concerning your information and specifically protects information that is individually identifiable health information or health related payment information.

D. Our Responsibilities

We are required by law to maintain the privacy of your protected information and are obligated to provide you with a copy of this notice. We reserve the right to make changes in our confidentiality provisions. Should any changes be made, a notice will be posted. Your health related information is contained within an individually marked file and is kept in a secure location. Access to this information is limited to employed staff members. We will set office practices in place that will aid in ensuring that information about you is not improperly released. Your treatment staff are either licensed in the State of Georgia or are supervised by staff who are licensed.

E. Possible Disclosures of Your Information

(The following are some of the ways information about you might be released.)

1. Audit Activities: Information may be disclosed to legally authorized agencies who audit or license our facility.
2. Abuse & Neglect: We may disclose protected health information to government authorities who are authorized to receive reports of abuse, neglect, or violence.
3. Legal Proceedings: We may disclose protected health information to judicial or administrative officers of the court in response to a subpoena or a court order.
4. Law Enforcement: Under certain specified legal conditions, disclosure of information may be made to law

enforcement officials.

5. Coroners/Medical Examiners: Information may be disclosed to coroners or other medical examiners for the purposes of determining the identity of a deceased person.
6. Threat to Safety: Consistent with Federal and State laws, we may disclose information if it is believed that disclosure is necessary to prevent or lessen an imminent threat to the health or safety of another person. For emergencies during non-work hours or if our staff are unavailable, please call 911.
7. Worker's Compensation: Information may be disclosed should it be necessary to comply with Worker's Compensation Laws.
8. Disclosures to You: You may request a change in your records if you believe that incomplete or inaccurate information is contained therein; request an Information Access/Change form. We are not required to agree with you or necessarily make those changes. You may appeal a denial of change of record or a denial of access to information to the Compliance Project Leader which will assign it for further review by a HIPAA Assessment Team Member.

We are required to disclose some of your protected health information when you request access. The regulations authorize a $20.00 administrative fee to be charged for each request. This fee will cover the administrative review of clinical issues, secretarial time involved with working with your file, and staff time to review the information in person with you. In addition, 75 cents per page (for 1-20 pages) or 65 cents per page (for 21-100 pages) will be assessed. There are exceptions to your receiving information about you from your file such as when civil or criminal actions are pending and involve the information contained in your file, or if the release of information would be harmful to you or to others. If the fees for your treatment services are not currently paid in full, services may no longer be provided to you, and/or access or copies of your file information will not be provided until your balance and fees associated with your treatment and review and possible copying charges are paid. Under the regulations, we have 30 days after your written request to provide you with the information. You may request an Information Access/Change Form from the office manager.

F. Complaints

For most complaints about your treatment, you should contact your counselor or the Director of your office. If you believe that we have violated your privacy rights, you may request a Privacy Complaint Form from the office manager which should be returned to: Project Leader, HIPAA Assessment Team, Atlanta Family Counseling Center, Inc., 190 Camden Hill Road, Suite A, Lawrenceville, GA 30045.

You may also file a complaint regarding privacy with the Secretary of the U.S. Department of Health and Human Services. At this level, the complaint should include what you have done to remedy your concern with Atlanta Family Counseling Center directly by including your original complaint and Atlanta Family Counseling Center's response. Your complaint must be in writing, contain the name of the company against which you are complaining, and be filed within 180 days from the date which you became aware or should have been aware of the issue. You will not be retaliated against for making any complaint.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE CLIENT'S RIGHTS AND RESPONSIBILITIES ABOVE, AND I HAVE READ AND/OR HAVE HAD MADE AVAILABLE TO ME THIS NOTICE OF PRIVACY PRACTICES:

Client's Signature _____ Date _____

ATLANTA FAMILY COUNSELING CENTER, INC.

Informed Consent

ABOUT OUR SERVICES...

In order to provide you with our services, we need your consent in writing. This consent will enable us to treat you in a responsible manner and keep all information confidential to ensure your privacy in accordance with O.C.G.A. 37-7-2, 40-5-1, and 40-5-631.

I understand that the information and records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and may not be disclosed without my written consent, with the exception of medical emergency, or if we feel you are about to harm yourself or others, or have committed a previously undisclosed crime which we are required to report to DFACS or other authorities.

Psychotherapy may involve the risk of remembering unpleasant events and discussing sensitive issues. I understand that this process is intended to help me better cope with life situations and to experience growth as a person.

ABOUT YOUR PAYMENT...

Payment is expected at the time of service unless other arrangements have been made. Co-payment is required at the time of service if you are using insurance. You will be responsible for payment if we are filing insurance for you and the insurance carrier does not pay the full amount charged.

ABOUT YOUR APPOINTMENT...

A notice of 24 hours must be given if you are unable to keep your appointment. Otherwise, you will be charged a $25.00 rescheduling fee.

I have read the above and understand that I will not receive services from Atlanta Family Counseling Center, Inc. without consent, and that I am responsible for all payments of services rendered by Atlanta Family Counseling Center, Inc.

Client Signature:_____ Date:_____

Witness 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

_____ _____
Witness Date