North Georgia Counseling Group, LLC

Client Intake Form

(Please print)

Date: _____ Referred by_____ May we thank them for the referral? Yes ____ No ____

How did you find us? Google Ad____Theravive_____Other Counseling Directory Site?_____If other, which one?_____

Identification

Name: _____ Date of Birth: _____ Age: _____

Marital status: _____ Male____Female ____ If client is a minor, resides with: Father____ Mother_____Both _____

Address: _____

City:_____State:_____Zip: _____

Contact Information

Ok to leave a message?

Home Phone: _____ Yes____No ____

Work Phone: _____ Yes____No ____

Cell Phone: _____ Yes____No ____

Email: _____ Yes____No ____

Responsible Party *(Person responsible for payment if different from above)*

Name:_____Relationship: _____

Address: _____

City:_____State:_____Zip: _____

Marital History

Spouse's Name	Years Married	Relational Issues?

Children

Name	Age	Gender	School & Grade	Behavioral or Adjustment Problems?	Quality of Relationship

Client:_____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Address: _____

Note: This will only be used in the event of a medical or psychological emergency in our offices.

Medical Care

Please list all Physicians you see regularly

_____	_____	_____
Name	Phone	Reason
_____	_____	_____
Name	Phone	Reason
_____	_____	_____
Name	Phone	Reason

Medication:_____Dosage:_____Reason:_____Date Started: _____

Medication:_____Dosage:_____Reason:_____Date Started: _____

Serious accidents, illnesses, or hospitalizations (please list):

_____	_____
Incident	Year
_____	_____
Incident	Year
_____	_____
Incident	Year

Health Issues

Appetite: Good____Average_____Poor ____

Sleep: Good____Average____Poor ____

Alcohol:_____drink(s) per _____

Tobacco: Yes____No ____

Recreational Drugs: Yes____No ____

High Blood Pressure: Yes____No ____

Thyroid problems: Yes____No ____

Diabetes: Yes____No ____

Any current medical problems? (Please list) _____

_____

Employment

Current Occupation: _____

How long? _____ Any issues with work? _____

Previous Occupation(s):_____

How long? _____ Any issues with work? _____

Client:_____

Family of Origin

Relative	Name	Age	Illness?	Education	Occupation	Quality of Relationship
Father						
Mother						
Step-Father						
Step-Mother						
Sibling						
Sibling						
Sibling						
Sibling						

Reasons for Seeking Counseling:

_____

_____

How have you attempted to solve the problems that have brought you to therapy?

_____

_____

Previous Counseling Experience

Therapist's Name	Clinic/Office Name	When/How Long?	City, State	Reason(s)

What was helpful about these experiences? What was unhelpful?

_____

_____

Are you a member of, or involved in, a church or religious group? If so, which one.

_____

_____

Client:_____

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below.
Please rate every item.

0 1 2 3 4 5 6 7 8 9 10
No Concern — *Moderate Concern* — *Extreme Concern*

Score	Issue	Score	Issue
	Anger		Mood Swings
	Abuse Victim		Problems with Children
	Aggression/Violence		Problems with Parents
	Anxiety		Problems with Social Relationships
	Attention/Concentration		Religious and/or Spiritual Concern
	Compulsions		Self-Harming Behavior
	Confusion		Sexual Concern
	Depression		Thoughts of Suicide
	Divorce/Separation		Trouble Making Decisions
	Education		Unhappy Most of the Time
	Eating/Appetite Problems		Unwanted/Intrusive Thoughts
	Fears of Specific Objects or Events		Use of Alcohol
	Grieving/Mourning		Use of Alcohol by Family Member
	Impulsiveness		Use of Other Drugs
	Financial Problems		Use of Other Drugs by Family Member
	Legal Problems		Work
	Marital Problems		Worry
	Medical/Physical Problems		Hallucinations
	Sleeping Problems		Smoking
	Thyroid Problems		Other (specify):

Client:_____

PLEASE NOTE: If you feel suicidal after office hours or you are unable to reach your counselor at any time, please call the suicide hotline at 1-800-227-8922. North Georgia Counseling Group, LLC does not operate as a crisis center and we do not carry pagers. We are only available during the hours your counselor is in the office. The assessment staff at Peachford Hospital is also available at 770-455-3200.

Client Signature: _____ Date: _____

Client:_____

Please review and discuss any questions you may have with your counselor.

The following information pertains to the treatment and financial policies of **North Georgia Counseling Group, LLC**.
Please sign and date this form at the bottom of the page. We will be happy to provide a copy for your records.

I. COUNSELING SERVICES: Counseling/Therapy is not easily described in general statements. It may vary depending on the personality of the client and the counselor and the specific problems being addressed. There are a number of different approaches that can be utilized to work on the problems you hope to address. It is different from medical treatment in that it requires a very active effort and commitment on your part. In order to be successful, you will need to work both in session and at home. There are both benefits and risks to counseling. The risks include experiencing uncomfortable levels of anxiety, sadness, anger, frustration, and a variety of other emotions. Counseling has also proven to have many benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, and better relationships and resolutions of specific problems. There are no guarantees about what will happen. Please discuss any reactions and emotions experienced during therapy with your counselor. By the end of the evaluation, your counselor will be able to offer you some initial impressions of what your work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with your counselor. Therapy involves a commitment of time, money, and energy. If there are any questions about procedures, please discuss them with your counselor when the issues arise. If your doubts persist, we will be happy to help you with a referral to another mental health professional.

II. PROFESSIONAL RECORDS: Both legal and professional standards require the keeping of appropriate treatment records. Because these are professional records, they can be misinterpreted and/or can be very upsetting. If you wish to see your records, please submit a request to your counselor. It is strongly recommended that these records be reviewed with your counselor to discuss their content. Clients will be charged an appropriate fee for any preparation time that is required to comply with an information request.

III. MINORS: If you are under eighteen (18) years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from parents that they consent to give up access to your records. If they agree, I will provide them only with general information on how your treatment is proceeding unless I feel that there is a high risk that you will seriously harm yourself or another, in which case I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before any information is disclosed, I will discuss the matter with you and attempt to resolve any objections or concerns you might have.

IV. CONFIDENTIALITY: In general, the confidentiality of all communications between a client and a counselor or therapist is protected by law, and I can only release information about our work to others with your written permission. However, there are a number of exceptions. In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he/she determines that resolution of the issues before him/her demands it. There are some situations in which I am legally required to take action to protect others from harm, even though it requires revealing some information about a client's treatment. If I believe that a child, an elderly person, or a disabled person is being abused, I am (may be) required to file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I am (may be) required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, I may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection. These are rare situations that have seldom arisen in my counseling practice. Should such a situation occur, I would make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together. While this summary of exceptions to confidentiality can be helpful in identifying potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. As you might suspect, the laws governing these issues are quite complex and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions of summaries of the applicable state laws governing these issues. In order to insure the highest possible standard of care, North Georgia Counseling Group, LLC, reserves the right to consult with staff members and appropriate professionals regarding your treatment. You will not be identified, and all consultation will be held in strict professional confidence. Your signature indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature: _____ Date: _____

(Guardian Signature for minor client): _____ Date: _____

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PAYMENT AGREEMENT

Professional fees are based on $125 for a standard 50 minute session. If needed, additional psychological assessments, consultations and reports will be discussed with you during your session and price will be given at that time. Brief professional services are billed at $25 per 15 minutes, or any part thereof, including telephone conversations. Fees will be periodically adjusted and clients will be notified in advance of the adjustment.

Professional fees will be assessed at the rate of $185 per hour, or any part thereof, for any services related to litigation, defense or other court related or case related activities. Such activities include interviews, evaluations, research, reports, correspondence, testimony, communication with attorneys, travel, and on-site time. In case of overnight travel, the maximum daily rate will be $750. Incidental expenses for professional services, such as, but not limited to, cost of travel, lodging, meals, will be billed to the client or his/her attorney.

Payment in full is expected at the time or in advance of services rendered. Statements will be provided for filing insurance claims for reimbursement. Nonpayment of fees will result in elimination of professional services and collection activity for amounts owed.

Since professional services are available only through prior scheduling, sessions canceled less than 24 hours in advance are charged at the full rate of the scheduled service.

Any variation from this payment agreement will require a separate, written agreement.

I have read this agreement and agree to its terms.

_____

Client/Legal Guardian

_____/_____/_____

Date

North Georgia Counseling Group, LLC

PLEASE READ: Form must be filled out by client *(or guardian if a minor)* to cover fee for canceled sessions with less than 24 hour notice.

Credit Card Authorization Form

Counselor: _____

Client(s) Name(s): _____

Credit Card#: _____

Name on Credit Card: _____

Card Type: MasterCard Visa American Express

Expiration Date: _____

Card Verification Code: _____

Billing Address: _____

Zip Code: _____

I agree that the credit card listed above may be charged for the therapy sessions and/or assessments of the client(s) named and therapy sessions canceled with less than 24 hours notice. This form and my credit card information will be held in my confidential client file until all billing has been completed and then destroyed promptly at the end of that time period.

_____ _____

Signature Date