Redman Counseling, LLC

678-447-5063

ADULT INTAKE FORM

This information and all communications with your therapist are kept confidential to the full extent of Georgia Law.

CLIENT INFORMATION

Name____Home Phone_____________________

Cell Phone____Work Phone______________________

E-mail Address____

May we use any of the above to remind you of your appointments? _____Yes _____No

May we leave a message? _____Yes _____No Circle the best way to reach you. Home Work Cell Email

Home Address____

City________________________________ST______________Zipcode__________________

Date Of Birth_____/______/__________

Employer__________________________Occupation___________________________Hrs/Wk____________

Can you be reached by phone? ____Yes ____No Work Phone:__________________________________

Age_____________ Sex: F M Race_____________________ Religious Preference______________

Church____Actively Attend? _____YES ______No

Presently living with: Parents__________Spouse_______Other:____________________________________

Maritial Status: Single______Married______ (yrs) Divorced_______(yrs) Other_____________________

Highest Education Completed: High School___________Elementary________College__________ Other________

SPOUSE INFORMATION

Spouse's Name____Date of Birth____________________

Address (if different)____Phone_________________________

Employer____Occupation___________________Hrs./wk_________

FAMILY MEMBERS (Living in household)

Name	Age	Relationship to Client
_________________________________	________	_______________
_________________________________	________	_______________
_________________________________	________	_______________

Describe any physical/mental problems you have that require medication or physical care:_____________

____

____

Medication (s) currently using:____

Are you currently receiving medical treatment? ____Yes ____No
If Yes, Name of Physician____

Previous Counseling/Therapy? ______Yes _____No If yes, when________________________________

Where and counseling with whom?____

Problem areas: From the following list, please **prioritize** any item which indentifies an area of concern to you by **numbering them** in order of importance. For example, the number "1" would be placed by the item which concerns you the most today.

______Anger/Temper
______Education
______Fearfulness
______ Physical Problems
______Problems with Children
______Sexual Concerns
______Trouble making decisions
______Use of Alcohol
______Work
_____Depression
_____Family Problems
_____Marital Problems
_____Problems with Social Relationships
_____Religious/Spiritual Concerns
_____Thoughts of suicide
_____Unhappy most of the time
_____Use of Drugs
_____Worry
______Other (specify):____

In your own words briefly describe the main problems which prompted you to seek counseling at this time.

____

____

Is there anything else which you believe might be important for your counselor to know at this time?

____

____

I was referred by:________________________________ May I thank them for the referral? ____Yes ____No
Their address, phone, or email if known____

Your Signature____Date__________________________

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INFORMED CONSENT AND OFFICE POLICY STATEMENT

I. Welcome!

Thank you for choosing Redman Counseling, LLC. The following information will acquaint you with information relevant to treatment, confidentiality, and policies. Please inform the therapist of any questions you have regarding any of these policies.

II. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychiatric treatment and/or psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. You may be asked to complete questionnaires or to do homework assignments.

III. Appointments:

Appointments are usually scheduled for 50-55 minutes. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency the therapist may be reached at (678) 447-5063. In the case of life threatening emergency if you are unable to contact your therapist call 911 or go to your local emergency room. You may also call the 24/7 GA Crisis Line at 1-800-715-4225.

IV. Confidentiality:

Counseling issues discussed between the therapist and identified client are important and are generally legally protected as both confidential and "privileged." Communications between the therapist and identified client will not be revealed unless required by law such as in situations as (1.) Suspected abuse or neglect of a child, elderly person or a disabled person (2.) When your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself (3.) Subpoena for court ordered release of information. Additionally confidentiality limits could be effected by: (a.) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc…; (b.) In natural disasters whereby protected records may become exposed; or (c.) When someone other than the therapist is present during the counseling session.

V. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section. Medical records are locked and kept on site.

Informed Consent & Office Policy Statement Continued on Page 2

VI. Fees:

Fee for the initial visit is $150.00
Each 55 minute session thereafter is $125.00

VII. Payments:

Payment is due at the time of the session unless other arrangements have been made. You can request a professional statement of charges. If a child\minor is a client the adult bringing the child to the appointment is responsible for the bill regardless of divorce decrees. However, the client is responsible for deductibles, co-insurance amounts and/or co-payments. Any unpaid balances will be billed. Our method of payments include Cash, Check, Money Order, Visa, MasterCard, Discover, and American Express.

VIII. Cancellations and Missed Appointments:

If you must cancel your appointment please notify your therapist (messages may be left via voicemail) at least 24 hours in advance of your scheduled appointment at 678-447-5063. A charge may be incurred (i.e. amount equivalent to the co-pay when using insurance; the session rate if "self-pay;" or loss of a visit if utilizing EAP services) when cancellations are received less than 24 hours in advance or the client does not show for the session, except in cases of illness or emergency. The client is responsible for this charge since insurance companies do not reimburse for missed appointments.

IX. Returned Check Fee:

There will be a $25.00 fee for any checks returned from your bank.

X. Termination of Services

If at any point you choose not to continue therapy please notify therapist of decision immediately so the chart can be closed. If you fail to reschedule an appointment within twelve weeks of your last session, therapy will officially be ended and you case will be deemed closed.

XI. Children

We cannot accept responsibility for the supervision of unattended children in the waiting room. If you are bringing your child to see a therapist, please bring another adult with you to supervise your child while you meet with the therapist. It is the responsibility of the person bringing the child to appointments to inform the custodial parent or the person who is the insured that insurance benefits are being utilized.

XII. Insurance

We will be glad to work with you by filing claims for you. However, it is ultimately your responsibility to see that authorizations or referrals are obtained and that the bill is paid. Utilization of your insurance benefits is likely to necessitate disclosure of clinical information to your insurance company.

XIII. Consent for Treatment

By signing below you: state that you have read and understood the Informed Consent Statement and Confidentiality Policy; have had your questions answered to your satisfaction; accept, understand, and agree to abide by the contents and terms of this agreement. I give my consent to enter a psychological counseling program and consent to participate in evaluation and/or treatment. I understand that signing this form does not commit me to a binding contract, but merely indicates my consent to begin therapy. I understand that I may withdraw from treatment at any time.

Signature ____ Date ____________________

****The signature of the custodial parent or legal guardian is required for clients under 18 years of age.**

____

Spouse' s Signature (if doing marital counseling) Date

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CLIENT INSURANCE INFORMATION

SECTION I: CLIENT INFORMATION

CLIENT'S NAME:____

CLIENT'S DATE OF BIRTH ________/________/_________

CLIENT'S ADDRESS: ____

CITY/STATE/ZIP ____

CLIENT'S TELEPHONE: HOME ___________________WORK ___________________ CELL ____________________

PATIENT'S RELATIONSHIP TO INSURED (circle one) SELF SPOUSE CHILD OTHER

SECTION II: PRIMARY INSURANCE INFORMATION

INSURED'S NAME: ____

INSURED'S DATE OF BIRTH _______/_______/_________

INSURED'S SOCIAL SECURITY # ____

INSURED'S ADDRESS ____

____

INSURED'S TELEPHONE: HOME _______________________WORK __________________ CELL _________________

INSURED'S INSURANCE PLAN NAME ____

POLICY OR GROUP NUMBER ______________________________________

INSURED'S EMPLOYER ____

IS THERE ANOTHER HEALTH INSURANCE PLAN?

SECTION III: SECONDARY INSURANCE INFORMATION

INSURED'S NAME: ____

INSURED'S DATE OF BIRTH _________/________/__________

INSURED'S SOCIAL SECURITY # _____________________________________

INSURED'S ADDRESS____

____

INSURED'S TELEPHONE: HOME ______________________WORK _________________ CELL _________________

INSURED'S INSURANCE PLAN NAME____

POLICY OR GROUP NUMBER ______________________________________

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Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers. As you might expect, the HIPAA laws and regulations are extremely detailed and difficult to grasp if you do not have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. It is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we make every effort to do what we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.
By law, Redman Counseling, LLC is required to secure your signature indicating you have been given access to a copy of the Patient Notification of Privacy Rights document.

Patient Name (print)____
I have read or will read a copy of the Redman Counseling, LLC Patient Notification of Privacy Rights document that provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document before signing this "acknowledgment form", and that I may at any time, now or later, ask any questions about, or seek clarification of, the matters discussed in this document.
Signing below indicates only that I have read or will read a copy.

(a) ____ ________________
Patient Signature Date

(b) ____ _________________
Parent Signature **(if patient is a Minor)** Date

(c) ____ __________________
Guardian Signature **(if patient is Legal Charge)** Date

(d) ____ __________________
Witness Date