The Psychology & Counseling Center, P.C.
17 Felton Place, Suite A, Cartersville, Georgia 30120 | (☎) 770.386.8996 (F)770.386.8100
(✉)info@pcccartersville.com

PATIENT INFORMATION FORM | Adult

This Form is Confidential

Today's date: ______________

Your name: ____
Last First Middle Initial

Date of birth: ____________________ **Social Security #:** ____________________________

Home street address: ____

City: _____________________________________ **State:** _______**Zip:**_________________

Name of Employer:____

Address of Employer: ____

City: _____________________________________ **State:** _______**Zip:**_________________

Home Phone: ________________________ **Work Phone:** __________________________

Cell Phone: ____________________ **Email:** ____________________________________

Calls will be discreet, but please indicate any restrictions:______________________________
____

Referred by: ____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency:

____
Name Relation Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): ________________________________

Insurance Information

Primary Insurance:____
Policy No: ________________________________ **Group No:** ____________
Policyholder Name:____
Last **First** **M.I.**
Policyholder Birthdate:_______________ **Policyholder SSN:**_______________
Relationship to Patient: _______________ **Responsible Party:** _______________

Secondary Insurance:____
Policy No: ________________________________ **Group No:** ____________
Policyholder Name: ____
Last **First** **M.I.**
Policyholder Birthdate:________________ **Policyholder SSN:** _______________
Relationship to Patient: ________________ **Responsible Party:** ______________

Please briefly describe your presenting concern(s): __________________________
____
____
____

What are your goals for therapy? _______________________________________
____
____
____
____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? ______________________

<u>MEDICAL HISTORY:</u>

Please explain any significant medical problems, symptoms, or illnesses: _______________
____
____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_______________

Do you consume caffeine? YES NO If YES, how much per day? _______________

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Please Initial ______

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? ____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_______________________

____

____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____________________

____

____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO

Date	Reason	Provider

Height _________ Weight _________ Age_________ Gender _________

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other: ________________

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

FAMILY:

How would you describe your relationship with your mother?____________________________

____

How would you describe your relationship with your father?_____________________________

____

Are your parents still married?_____________ If they divorced, how old were you when they separated or divorced, and how did this impact you? ______________________________________

____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: ____________________________________

____

How many sisters do you have? ______ Ages? ______________________________________
How many brothers do you have? ______ Ages? ____________________________________
How would you describe your relationships with your siblings? ______________________________

____

Please Initial ______

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships________________________

Do you have Children?____ If YES, how many and what are their ages:______________________

Describe any problems any of your children are having: ________________________________
____

List the names and ages of those living in your household: ______________________________
____

Please briefly describe any history of abuse, neglect and/or trauma: ________________________
____
____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:______________________________
____
____

Is spirituality important in your life and if so please explain:______________________________
____

Briefly describe your diet and exercise patterns:_______________________________________
____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant?____________________________________
____

What do you think are your strengths?____
____
____

Any additional information you would like to include:

____
____
__________________________.

Please Initial ______

Please check all that apply and circle the main problem.

Difficulty With:	Now	Past	Difficulty With:	Now	Past	Difficulty With:	Now	Past
Afraid of the Dark or Storms			Fears:			Nightmares / Night Terrors		
Alcohol/Drugs			Feeling as if he/she is choking			Obsessed with Specific Objects/Topics		
Allergies			Feeling Dizzy, lightheaded or faint			Often Makes Careless Mistakes		
Amphetamine Use			Feeling like you're going crazy			Other repetitive behaviors (that reduce anxiety/nervousness)		
Anger or Temper			Feeling Restless or Slowed Down			Panic		
Angry & Resentful			Feeling Worthless or Guilty			Paranoia (Feels others are out to get them)		
Annoys other on purpose			Fidgets Frequently			Parents Divorced		
Anxiety			Fighting with Siblings			Poor Social Skills		
Arguing			Forgetful			Pounding Heart		
Avoiding Situations related to trauma			Frequent Vomiting			Problems in School		
Bedwetting			Gambling			Problems with Friend(s)		
Binge Eating			Gets into physical fights			Problems with organization		
Blocking Out Memories related to trauma			Getting to Sleep			Racing thoughts		
Blurts Out/Talk without Thinking			Has harmed others with a weapon (knife,gun,bat,bottle)			Recurrent Thoughts or Images		
Bruises Easily			Head Injury			Recurring thoughts related to trauma		
Bullies/threatens others			Headaches			Refusing to Speak		
Chest Pain			Hearing Voices			Repetitive Hand washing, Cleaning, etc.		
Chills or Hot Flashes			Heart Problems			Repetitive Movements		
Communicating			History of Child Abuse			Running Away from Home		
Completing Tasks			History of Sexual Abuse			Seeing Things that Others Do Not		
Concentration			History of Trauma or abuse			Seizures		
Constant Nervousness or Worrying			Hurting Self			Severe Weight Gain		
Cries Easily			Hyperactivity			Severe Weight Loss		
Cruel to Animals			Identity or Gender Issues			Sexual Problems		
Damages property			Impulsiveness			Sexually Acting Out		
Defies Adults			Inattention			Shaking or Trembling		
Depressed Mood			Increased Pleasurable Activities (sex, shopping, etc)			Shortness of Breath		
Depression			Increased Self-esteem			Skipping school		
Diarrhea			Inhalant Use			Sleeping Alone		
Distracted Easily			Insomnia or Oversleeping			Sleeping Too Little		
Dizziness			Interrupts Others			Sleeping Too Much		
Does Not Listen			Irritability			Sleepwalking		
Domestic Violence			Issues Re: Divorce			Smearing Feces		
Easily Distracted by Noises			Lack of Eye Contact			Smoking Cigarettes		
Eating non-edible things			Lack of Pleasure in Activities			Soiling Pants		
Eating Problems			Language Delays			Spiteful or Vindictive		
Excessive energy			Learning Problems			Stealing Objects		
Excessive talking			Less Need for Sleep			Stomach Aches		
Excessive Use of Caffeine			Loses things Easily			Stuttering		
Excessive Worry			Loss of Energy			Sweating		
Extreme Exercising or Dieting			Loss of Memory			Tantrums		
Extreme Startle Response			Low Intelligence			Thoughts of Death		
Fainting			Lump in the Throat			Thoughts of Hurting Someone Else		
Falling asleep at inappropriate times			Making yourself sick or vomiting			Thoughts of Suicide		
Fear of Dying			Marijuana Use			Trusting Others		
Fear of Leaving the house			Mood Changes			Urinating in Pants		
Fear of New Situations			More Talkative than Usual			Waiting His/Her Turn		
Fear of social situations			Motor Delays			Waking Too Early		
Fear of Strangers			Muscle Tension			Will Not Separate from Parents		
Fear related to Trauma or Abuse			Nausea and/or Stomachaches			Other:		

Please Initial ______

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INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to The Psychology and Counseling Center, P.C. (PCC). We are very pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist or group leader, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at PCC. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information, Theoretical Views, & Client Participation

Information regarding your therapist's educational background and experience may be found on our website under his or her name. Please feel free to view that information at www.psychologistsofcartersville.com

It is our belief that as people become more aware of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist/group leader at any point (unless appointed by legal counsel).

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more you are willing to invest in yourself, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life’s challenges in the future without your therapist. We also don’t believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit. If at any point you are unable to keep your appointments, or we don't hear from you for one month, we will need to close your chart. However, reopening your chart and resuming treatment is always an option.

Confidentiality & Records

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our locked office. There are a few other people who may also have access to your PHI. One of our administrative assistants or our business manager may need to access your chart on occasion for business purposes only. This might be to check for dates of services to file an insurance claim (if applicable), to ascertain that all of the HIPAA required documentation is located in the chart (occasional audit of charts), or some other absolutely necessary business practice. However, please know this would never include reading any of your clinical notes. Additionally, each

business associate has signed a HIPAA enforced confidentiality contract which spells out how confidential records must be handled.

Your therapist will always keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. This state has a very good track record in respecting this legal right . If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

Professional Relationship

Your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may need to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

There is another dual relationship that therapists are ethically required to avoid. This is providing therapy while also providing a legal opinion. These are considered mutually exclusive unless you hire a therapist specifically for a legal opinion, which is considered "forensic" work and not therapy. Our passion is not in forensic work but in providing you with the best therapeutic care possible. ***Therefore, by signing this document, you acknowledge that your therapist will be providing therapy only and not forensic services.*** You also understand that this means your therapist will not participate in custody evaluations, depositions, court proceedings, or any other forensic activities.

You should also know that therapists are required to keep the identity of their clients confidential. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Please Initial ______

Statement Regarding Ethics, Client Welfare & Safety

PCC assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association, the American Counseling Association, the National Association of Social Workers, and the American Association for Marriage and Family Therapy. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact the PCC Practice Manager, at 770.386.8996 ext. 210.

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

For the safety of all our clients, their accompanying family members and children, and our therapists and staff, PCC maintains a zero tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes, or anything that could be harmful to yourself or others. PCC reserves the right to contact law enforcement officials and/or terminate treatment with any client who violates our weapons policy.

TeleMental Health Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. TeleMental Health is defined as follows:

> "TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, our therapists have completed specialized training in TeleMental Health. We have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

Please Initial ______

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:
It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided us with that phone number, we may contact you on this line from our own landline in our office or from a cell phone, typically only for purposes of setting up an appointment if needed. If this is not an acceptable way to contact you, please let your therapist know. Telephone conversations (other than just setting up appointments) are billed at your therapist's hourly rate.

Cell phones:
In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, we realize that most people have and utilize a cell phone. We may also use a cell phone to contact you, typically only for purposes of setting up an appointment if needed. Additionally, your therapist may keep your phone number in his/her cell phone, but it will be listed by your initials only and his/her phone is password protected. If this is a problem, please let your therapist know, and you he/she will be glad to discuss other options. Telephone conversations (other than just setting up appointments) are billed at your therapist's hourly rate.

Text Messaging:
Text messaging is not a secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is our policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that we are required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Even though we will only utilize texting for appointments, we utilize a special text messaging software called Office Ally for your added protection. We have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and the company has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. We encourage you to also utilize this software if you do not wish for others to have access to your communications. We also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., password protected).

Email:
We utilize a secure email platform that is hosted by Google. We have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. If we choose to utilize emailing as part of your treatment, we encourage you to also utilize this kind of software for protection on your end. Otherwise, when you reply to one of your therapist's emails, everything you write in addition to what he/she has written to you (unless you remove it) will no longer be secure. Our encrypted email service only works to send information and does not govern what happens on your end.

Please Initial ______

We also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to us via email because we may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

Email is billed at your therapist's hourly rate for the time she or he spends reading and responding to them. If you are in a crisis, please do not communicate this to us via email because we may not see it in a timely matter. Instead, please see below under "Emergency Procedures." Finally, you also need to know that we are required to keep a copy or summary of all email as part of your clinical record that address anything related to therapy. Email communication regarding appointment scheduling will not be billed, but must be sent through the front office and not through your therapist. Please utilize: info@pcccartersville.com for all appointment requests.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:
It is our policy not to accept "friend" or "connection" requests from any current or former client on any of our therapist's **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of your relationship.

Video Conferencing (VC): Video Conferencing is an option for your therapist to conduct remote sessions with you over the internet where you may speak to one another as well as see one another on a screen. We utilize Skype, and at the present time Skype is NOT willing to sign a BAA and is not recommended. This VC platform is not encrypted to the federal standard, not HIPAA compatible, and will not sign a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assumes responsibility for keeping your VC interaction secure and confidential. If you and your therapist choose to utilize this technology, you need to consider the potential risk. We ask that you please sign on to the platform at least five minutes prior to your session time to ensure you and your therapist get started promptly. Additionally, you are responsible for initiating the connection with your therapist at the time of your appointment.

We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Recommendations to Websites or Applications (Apps):
During the course of our treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. She or he may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that your therapist does not make these recommendations. Please let your therapist know by checking (or not checking) the appropriate box at the end of this document.

Electronic Record Storage:
Your communications with us will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with Office Ally, a secure storage company who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption.

Please Initial ______

Electronic Transfer of PHI for Billing Purposes:
If your therapist is credentialed with and a provider for your insurance carrier, please know that we utilize a billing service who has access to your PHI. Your PHI will be securely transferred electronically to Office Ally. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, our billing company, or both.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

In Case of Technology Failure

During a TeleMental Health session, you and your therapist could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and your therapist has that phone number.

If you and your therapist get disconnected from a video conferencing or chat session, end and restart the session. If you are unable to reconnect within ten minutes, please call your therapist.

If you and your therapist are on a phone session and you get disconnected, please call your therapist back or contact her or him to schedule another session. If the issue is due to your therapist's phone service, and the two of you are not able to reconnect, she/he will not charge you for that session.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in our office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, your therapist might not see a tear in your eye. Or, if audio quality is lacking, he or she might not hear the crack in your voice that he or she could have easily picked up if you were in our office.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that we have the utmost respect and positive regard for you and your wellbeing. We would never do or say anything intentionally to hurt you in any way, and we strongly encourage you to let your therapist know if something she or he has done or said upset you. We invite you to keep the communication with your therapist open at all times to reduce any possible harm.

Face-to Face Requirement

If you and your therapist agree that TeleMental Health services are the **primary** way that you and your therapist choose to conduct sessions, **we require one face-to-face meeting at the onset of treatment.** This initial meeting will take place in our office.

Please Initial ______

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing your therapist to utilize for your treatment or administrative purposes. You and your therapist will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying us in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to our practice, and we will be utilizing that technology unless otherwise negotiated by you.

- ☐ Texting
- ☐ Email
- ☐ Video Conferencing
- ☐ Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that we are open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Communication Response Time

Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. We will return phone calls, texts, and email within 24 hours. However, we do not return any form of communication on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911.
- Go to the emergency room of your choice.

If you & your therapist decide to include TeleMental Health as part of your treatment, there are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, we may determine that you need a higher level of care and TeleMental Health services are not appropriate.

- We require an Emergency Contact Person (ECP) who we may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or we will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or we determine necessary, the ECP agrees take you to a hospital.

Please Initial ______

Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above. Please list your ECP here:

Name: ____ Phone: ______________________

- You agree to inform your therapist of the address where you are at the beginning of every TeleMental Health session.

- You agree to inform your therapist of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:

Hospital: ____ Phone: _______________________

Fee Schedule and Assignment of Benefits

We offer primarily face-to-face therapy sessions. However, based on your treatment needs, your therapist may provide phone, text, email, or video conferencing (TeleMental Health). The structure and cost of both in-person sessions and TeleMental Health is $200 per 60 minute, initial session, and $150 per 45 minute session unless otherwise negotiated by your insurance carrier. The fee for each session will be due upon sign in at reception. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and we will provide you with a detailed receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $30 fee for any returned checks.

Phone calls, texting, and emails (other than setting up appointments) are billed at PCC's hourly rate for the time spent reading and responding. We require a credit card ahead of time for TeleMental Health therapy for ease of billing. Please sign the Credit Card Payment Form, which was sent to you separately and indicates that we may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental Health interaction. **Again, this includes any therapeutic interaction other than setting up appointments.**

Insurance companies have many rules and requirements specific to certain plans. For example, most insurance companies will not cover therapy over the telephone, text, or email. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement should it not be billable through our standard billing practice. As mentioned above, we will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Initial Assessment | $200.00 per 45 min
Family/Couples Therapy | $150.00 per 45 min
Psychological/Educational Evaluation | Up to $2500.00 (No Ins)
Drug and Alcohol Evaluation | $200.00 +

Individual Therapy | $150.00 per 45 min
Emergency Session | $175.00 per 45 min
Surgical Evaluation | $400.00 + (No Ins.)
No Show and Late Cancel Fee…$50.00

Record Request, Copy, Report/Letter Writing, Re-Print Fee | $25.00
Superior/Juvenile Court Fee | Forensic Fee Sheet Required.

*** Rates do not apply to records requests necessary to make or complete an application for a disability benefits program or vocation rehabilitation program.***

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the payment of any professional service rendered.

I agree to pay for all office visits to my physician that exceeds the allowed number of visits that are covered by my insurance company during any calendar year. I do understand that it is my responsibility to know how many visits I am allowed during the calendar year by my insurance company, as well as any copays, coinsurance and/or deductible amounts.

I hereby authorize and request the insurer(s) that I am covered under to pay directly to the business at 17 Felton Place, Suite A, Cartersville, GA 30120 any benefits due under the terms of the policies. I authorize payment of medical benefits to the physician or supplier for services rendered

I understand and agree to pay the $50.00 fee if I fail to cancel my appointment within 24 hours or miss the appointment.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment of my medical care.

Please Initial ______

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify the office (Phone Msg and email are acceptable) at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. PCC's cancellation fee is $50 per missed session. Please note that insurance companies do not reimburse for missed sessions.

Our Agreement to Enter into a Therapeutic Relationship

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form **as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"** provided to you separately. Your signature also indicates that you agree to the policies of your relationship with your therapist and/or group leader, and you are authorizing your therapist and/or group leader to begin treatment with you. Please note that this updated Information, Authorization & Consent to Treatment" replaces any previously signed informed consents.

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please inquire at the front desk.

____ ________________
Client Name (Please Print) **Date**

____
Client Signature

If Applicable:

____ ________________
Parent's or Legal Guardian's Name (Please Print) **Date**

____
Parent's or Legal Guardian's Signature

____ ________________
Parent's or Legal Guardian's Name (Please Print) **Date**

____
Parent's or Legal Guardian's Signature

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

____ ________________
Therapist's Signature **Date**

Please Initial ______

The Psychology & Counseling Center, P.C.
17 Felton Place, Suite A, Cartersville, Georgia 30120 | (☎) 770.386.8996 (F)770.386.8100
(🖂) info@pcccartersville.com

CREDIT CARD PAYMENT RECORD

Client Name as it Appears on Card: ____

Card Number: ____ Expiration Date: __________

Credit Card Billing Information: __________________ _____________ _____________
Street Number Zip Code Security

Client Signature: ____

(Your signature indicates that you agree to allow your therapist to make charges on your card without you present and to store this information in an electronically encrypted HIPAA compliant manner.)

Therapist's Name: ____

Description of Service	Date of Session	Date Posted	Amount Posted	Authorization Code	Recorder's Initials

Health Insurance Portability and Accountability Act (HIPAA)

Please Initial ______

NOTICE OF PRIVACY PRACTICES

I. COMMITMENT TO YOUR PRIVACY: *The Psychology and Counselign Center (PCC)* is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that *PCC* maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, *PCC* is required to ensure that your PHI is kept private. This Notice explains when, why, and how *PCC* would use and/or disclose your PHI. Use of PHI means when *PCC* shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when *PCC* releases, transfers, gives, or otherwise reveals it to a third party outside of the *PCC.* With some exceptions, *PCC* may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, *PCC* is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by *PCC* Please note that *PCC* reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that *PCC* has created or maintained in the past and for any of your records that *PCC* may create or maintain in the future. *PCC* will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of *PCC* Notice of Privacy Practices.

IV. HOW PCC MAY USE AND DISCLOSE YOUR PHI: ***PCC*** will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: *PCC* may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, *PCC* may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, *PCC* will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: *PCC* may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

3. To Obtain Payment for Treatment: *PCC* may use and disclose your PHI to bill and collect payment for the treatment and services *PCC* provided to you. Example: *PCC* might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. *PCC* could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for *PCC* office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, *PCC* will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to *PCC* by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, *PCC* will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of *PCC*.

Note: This state and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how *PCC* may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – PCC may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, *PCC* may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: *PCC* may make a disclosure to the appropriate officials when a law requires *PCC* to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** *PCC* may disclose information about you to respond to a court or administrative order or a search warrant. *PCC* may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. *PCC* will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.

Please Initial ______

3. **Public Health Risks:** *PCC* may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** *PCC* may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** *PCC* may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if *PCC* determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, *PCC* may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), *PCC* may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** *PCC* may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If *PCC* has a reasonable suspicion of child abuse or neglect, *PCC* will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** *PCC* may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. *PCC* may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** *PCC* may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, *PCC* may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, *PCC* may release PHI about you as required by military command authorities. *PCC* may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** *PCC* may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, *PCC* may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, *PCC* may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:** *PCC* may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** *PCC* is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** *PCC* may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess *PCC*'s compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**
18. **In the Following Cases, *PCC* Will Never Share Your Information Unless You Give us Written Permission:** Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, *PCC* will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying *PCC* in writing of your decision. You understand that *PCC* is unable to take back any disclosures it has already made with your permission, *PCC* will continue to comply with laws that require certain disclosures, and *PCC* is required to retain records of the care that its therapists have provided to you.

Please Initial ______

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in *PCC*'s possession, or to get copies of it; however, you must request it in writing. If *PCC* does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from *PCC* within 30 days of receiving your written request. Under certain circumstances, *PCC* may feel it must deny your request, but if it does, *PCC* will give you, in writing, the reasons for the denial. *PCC* will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. *PCC* may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that *PCC* limit how it uses and discloses your PHI. While *PCC* will consider your request, it is not legally bound to agree. If *PCC* does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You do not have the right to limit the uses and disclosures that *PCC* is legally required or permitted to make.

3. The Right to Choose How *PCC* **Sends Your PHI to You:** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). *PCC* is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that *PCC* has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

PCC will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. *PCC* will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Choose Someone to Act for You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that *PCC* correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of *PCC's* receipt of your request. *PCC* may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than *PCC*. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and *PCC's* denial will be attached to any future disclosures of your PHI. If *PCC* approves your request, it will make the change(s) to your PHI. Additionally, *PCC* will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to *PCC's* Director and Privacy Officer, Sarah Bastings, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision *PCC* made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. *PCC* will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. *PCC's* **Responsibilities:** We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Date of Last Revision: 1.1.18

Please Initial ______

PSYCHOLOGY & COUNSELING CENTER, P.C.
17 Felton Place, Suite A
Cartersville, Georgia 30120
Phone: 770-386-8996 Fax: 770-386-8100
Email: info@pcccartersville.com

William B. Moon, Ph.D.
Jonathan Hill, Ph.D.
Sharon Rinks, Psy.D.

Robert F. Norton, Ph.D.
Jennifer Johnson, Psy.D.
Kim Roberts, LPC, CRC, CAADC

Authorization to Release Confidential Information

Patient Name: ___________________________________ Date of Birth: ______________

I hereby authorize the release of my confidential, psychological, educational and/or other appropriate information acquired during my evaluation and treatments, or those of my minor children, by phone, mail email or fax.

CIRCLE ONE OR BOTH
TO/FROM:
Psychology and Counseling Center
17 Felton Place, Suite A
Cartersville, GA 30120
Phone/Fax/Email Listed Above

CIRCLE ONE OR BOTH
TO/FROM: _________________________________
Relation: _Primary Care Physician______________
Phone: ___________________________________
Fax: _____________________________________
Email: ___________________________________

CHECK ALL WHICH APPLY:
_______All Records
_______Specific Records:
____

I understand that this consent will be valid for one (1) year from the date signed. I may also revoke this consent at any time by informing the above parties in writing. In consideration of this consent, I hereby +release the above parties from any legal liabilities for the release of this information.

____
Printed Name of Patient

____ __________________________
Signature of Patient or Legal Guardian Date

Please Initial ______